ANGLIA RUSKIN UNIVERSITY
FACULTY OF SCIENCE AND ENGINEERING
SCHOOL OF PSYCHOLOGY AND SPORT SCIENCE

THE IMPORTANCE OF BEING HUMANE: A CASE STUDY OF A POSITIVE PRACTICE WARD AND A MIXED METHODS EXPLORATION OF THE DEVELOPMENT AND ACCEPTABILITY OF THE PERSONAL NARRATIVE MODEL

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Confirmed by Dr Emma Kaminskiy

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ABSTRACT

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Scant research explores positive practice within specialist inpatient services for service users (SUs) with a diagnosis of borderline personality disorder (BPD). Few collaboratively developed models of psychological formulation exist despite it being a possible support for positive practice for SUs with a diagnosis of BPD.

This research employed a two-stream Mixed Methods-Case Study design to address these gaps. In Stream 1 an interview-based case study of SU (n = 6) and staff (n = 10) perspectives on a positive practice specialist ward (Poppy) identified explanatory factors of positive experience as well as barriers. Psychological formulation was identified as a means to support existing positive practice while addressing identified barriers, including the care-planning processes. Stream 2 entailed a mixed-methods acceptability exploration of the model of formulation developed collaboratively for this research (the Personal Narrative Model; PNM). This included a focus group with Poppy staff (n = 7) and an online phase of qualitative and quantitative surveys (n = 26) and interviews (n = 8) with a wider practitioner and lived experience sample.

Findings revealed positive practice is defined by staff and SUs as good relationships, staff specialist training and knowledge, and sharing responsibility for risk and recovery. Care-planning was seen as collaborative, but staff found the process lacks meaning. The PNM was suggested to address this. Logistical and other barriers impeded its implementation at Poppy; however, the online phase confirmed general acceptability. Participants reported support would be required to address the risk of narrative for staff and SUs. Overlap across participants and research phases identified both implementation challenges (e.g., staff resistance and barriers to collaboration) and ways to address them.

The contribution to knowledge includes: (a) explanatory factors of positive experiences in a specialist context; (b) acceptability of the PNM, which possibly addresses less positive practice (aversion to narrative; theoretical incoherence of care-planning); and (c) challenges of applying new practices in a specialist inpatient context and recommendations for their management.

Keywords: Mixed Methods-Case Study; borderline personality disorder, specialist inpatient ward, psychological formulation, positive practice, collaborative practice

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Abbreviations

ACT	Acceptance and Commitment Therapy
BPD	Borderline personality disorder
BPS	British Psychological Society
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CMHT	Community Mental Health Team
CQC	Care Quality Commission
DBT	Dialectical Behavioural Therapy
DCP	Division of Clinical Psychology
DoH	Department of Health
DSM	Diagnostic and Statistical Manual
HCA	Healthcare Assistant
HRA	Heath Research Authority
IAPT	Improving Access to Psychological Therapies Service
MDT	Multidisciplinary Team
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
PAR	Participatory Action Research
PNM	Personal Narrative Model
PRT	Positive Risk-Taking
PTMF	Power Threat Meaning Framework
REC	Research Ethics Committee
RTA	Reflexive Thematic Analysis
SDM	Shared Decision Making
UK	United Kingdom

Glossary

BPD	A contentious psychological diagnosis defined by interpersonally, emotionally, and self-identity-based distress.
Case Study	A richly detailed examination of a group, unit, or organisation.
DBT	A talking therapy developed specifically to address the difficulties experienced by individuals with a diagnosis of BPD.
MDT	An assembly of professionals from various backgrounds contributing within their individual capacities to a shared purpose.
Mixed Methods	The combination of qualitative and quantitative research method within a research undertaking.
PNM	A collaborative psychological model of formulation introduced in this thesis.
Positive Practice	Care practices defined by service users and/or practitioners as promoting dignity, respect, independence, and the development of skills. Including but not limited to SDM, PRT, and trauma-informed care.
PRT	An orientation which, in clinical decision-making, favours the dignity, growth and potential of individuals over (risk-averse) organisational interests.
Psychological formulation	A process undertaken by clinical psychologists or other professionals in partnership with a service user to bring together a shared understanding of past experiences, current ways of living, and any difficulties whilst incorporating meaning throughout. Its goal is to identify a jointly agreed way forward for the individual.
PTMF	A recent, more contextually informed meta-framework presented as an alternative to traditional, medicalised ways of understanding people's distress and distressing behaviour.
SDM	A process of joint decision-making in the health or mental health context during which both a professional and a service user make care decisions. It is based on the acknowledgement of equally important and distinct expertise.

Appendices

Copyright Declaration

1. Chapter 1 Introduction and Context

Through this thesis, I aimed to gain insight into positive practice in specialist inpatient services for service users with a diagnosis of borderline personality disorder (BPD), a diagnosis thought to pose a particular therapeutic challenge (Bowen, 2013). Little research exists on positive practice or 'what works,' especially in specialist services. This research explores the perspectives of staff and service users on a positive practice ward through the use of case study.

Barriers to positive practice continue to exist even in a positive practice context, particularly those related to the care-planning process. Psychological formulation was proposed to address these barriers as well as support existing positive practices. Few formulation models exist that were developed collaboratively. This research involved the development of such a model, the Personal Narrative Model (PNM) to address needs 'on the ground.' The acceptability of the PNM both in the context of the specialist ward and elsewhere was explored using mixed methods.

The journey to this thesis has been circuitous; Appendix A provides a narrative account of this process.

1.2 Context

A description of the context of this work is of central importance to situate the research and provide overall coherence.

Years prior to this research taking place, an organisation within the East of England, here referred to as 'Enhance' worked together with their local National Health Service (NHS) Trust to reduce the use of coercion, specifically restraint, by improving service user experiences of services. Two advisory groups (one comprised of service users and another of staff) in addition to a multidisciplinary steering group informed their initiative, which included research, policy changes, upgrades to physical ward environments, and staff training. Enhance was largely successful in its mission with a dramatic decrease in the use of restraint and improvement in overall service user experiences. This combined with a research and training initiative on shared decision making (SDM) created an apparent cultural shift.

One ward, which has been assigned the pseudonym 'Poppy' throughout this thesis, particularly benefitted from this service renaissance. Poppy ward is a specialist inpatient ward for women with diagnosis of personality disorder, mainly borderline personality disorder

(BPD). Poppy has approximately 10 beds (number approximate to maintain anonymity) and offers two 6-month rounds of Dialectical Behaviour Therapy (DBT), a treatment developed by Marsha Linehan (Linehan & Kehrer, 1993) specifically to address the difficulties faced by service users with a diagnosis of BPD. DBT theory of BPD involves two components: the biological, which assumes service users with a diagnosis of BPD experience emotional dysfunction because of a biologically (although not necessarily genetically; Linehan, 1993) determined emotional vulnerability, and the social-environmental, which refers to early invalidating experiences and responses. DBT is derived from Cognitive Behavioural Therapy (CBT) and principles of the Zen Buddhist tradition. Its key features of implementation involve individual therapy sessions along with group sessions.

BPD is a particularly contentious psychiatric diagnosis (Campbell et al., 2020; Duff et al., 2020). Critical researchers believe BPD is a gendered diagnosis (Ussher, 2013), construed as an 'exaggerated femininity' that pathologizes self-harm, anger and impulsivity, all features of the BPD diagnostic criteria. 50-80% of those given this diagnosis are women and it is highly stigmatised in the mental health community (Ussher, 2013). Despite evidence to indicate the possibility of 'full clinical recovery,' a history of BPD being seen as 'untreatable' has often resulted in widespread therapeutic nihilism, according to Campbell and colleagues (2020). Unhelpful perceptions around this 'group' being difficult to work with, impossible to rehabilitate, and manipulative abound (Bowers, 2005); however, research demonstrates individuals who receive this diagnosis tend to have experienced trauma and thus are likely to be reacting to their current environments and interactions in understandable ways. Psychotropic medication has been found to be commonly administered to service users with a diagnosis of BPD, with low rates of psychological treatment offered (Hermens et al., 2011; Kadra-Scalzo et al., 2021).

Poppy ward management began implementing SDM and positive risk taking (PRT) practices shortly after the inception of Enhance and have continued since. The ward now only treats service users who attend voluntarily and has abandoned restraint, seclusion, and rapid tranquilisation practices. It is particularly important to highlight Poppy's orientation towards recovery-promoting practices as well as their rejection of coercive practices given the practices and attitudes which exist on other inpatient wards. Research indicates service users with a diagnosis of BPD often feel coerced into involuntary admissions (Stapleton & Wright, 2017) and are given little choice in treatment decisions, particularly in relation to medication (Borschmann et al., 2014). There is a further perception that any form of noncompliance is pathologized (Warrender et al., 2019). Damsa and colleagues (2007) described 80% of

participants in their study being restrained before they were given medication. Thus, relative to mainstream services, Poppy's progressive attitudes are uncommon and its context is unique amongst services for individuals with a diagnosis of BPD. This is important to bear in mind while interpreting the results presented within this thesis and their situatedness.

As a next stage following the success of these interventions, Enhance commissioned this studentship with the view that the unique context presented by Poppy ward allows for an exploration of both its existing positive practices as well as ways to extend them. Psychological formulation has been identified in the literature as a positive practice tool (see Chapters 2 and 7) and was endorsed by Poppy gatekeepers to possibly offer the means to address the gaps identified in Poppy ward, including the need to improve the care-planning process while continuing to support existing positive practices.

This research setting offered an opportunity to explore how psychological formulation may be useful to both service users with a diagnosis of BPD and those who work with them in the context of a specialist personality disorder service. Further, this context allowed for an investigation of whether a formulation model developed in collaboration with a local Service User Advisory Group (SUAG; see Chapter 4) would be acceptable to Poppy ward staff alongside a wider online investigation exploring both mental health practitioners and those with lived experiences' views of acceptability.

1.3 Aims and Research Questions

The aims identified for this research include:

1) To explore staff and service user experiences of treatment on a positive practice ward; 2) to describe the development of the PNM, a collaboratively developed model of psychological formulation; 3) to explore the acceptability of the PNM in a specialist inpatient context; and 4) to explore the wider acceptability of the PNM.

To address these four aims, the research entails two streams of research that address the following research questions.

1.3.1 Stream 1

1. What factors do members of a multidisciplinary team (MDT) believe are involved in the operation of a positive-practice specialist ward for service users with a diagnosis of personality disorder?
2. What factors do service users believe are involved in the operation of a positive-practice specialist ward for service users with a diagnosis of personality disorder?

1.3.2 Stream 2

3. What does a model of psychological formulation, collaboratively developed alongside local stakeholders to address their needs, look like?
4. What are specialist inpatient staff views of the PNM and its acceptability? What are the enablers and barriers?
5. What are wider stakeholder (clinicians and/or individuals with lived experience of mental health difficulties) views of the PNM and its acceptability? What are the enablers and barriers?

1.4 Contribution and Main Findings

This thesis adds to the existing body of research on positive experience of specialist inpatient services. The results further support that service users value humane, friendly, normalising treatment and that this is possible to provide in a context of specialist services. The findings relating to care-planning offer an inverse pattern compared to that found in existing research (Coffey et al., 2019), which may indicate the need for care-planning approaches to cohere with the theoretical modality in operation within a service in order for it to be implemented and experienced meaningfully. The PNM is one of the few known models of formulation to be developed collaboratively. Findings indicate it supports positive care and has the potential to support and enhance positive care practices, including SDM, PRT, and a whole-person approach. Challenges for and enablers of the PNM's implementation are based on a host of perspectives, practitioners and participants with lived experience alike. Substantial overlap in perspectives was found, which offers insight for future researchers and application in other settings.

The case study found that positive experiences of treatment for both staff and service users are contingent on good relationships defined by a sense of friendly community; sharing of responsibility for recovery and risk; and specialist staff knowledge and understanding of DBT and BPD through training and experience. Findings demonstrate that SDM and PRT are possible within the applied context of specialist services and suggests possible enabling factors. The combination of these factors was thought to result in the avoidance of coercive practices. Staff and service users' experiences of care-planning diverged in that while both believed its process to be collaborative, service users indicated their experience of care-planning was helpful and positive while staff questioned the meaningfulness of the process.

Psychological formulation was identified as a possible support for meaningful care-planning as well as to support and enhance existing positive practices (PRT, SDM, therapeutic relationships). A collaboratively developed model of psychological formulation, the PNM, was thus developed. Using mixed methods, the PNM was tested for its acceptability with both specialist staff as well as a wider (online) sample of mental health practitioners and individuals with lived experience. This revealed the PNM's general acceptability alongside challenges to and enablers of its implementation within services. Possible challenges included staff resistance to change, barriers to collaboration with service users, and the possible risks involved for both staff and service users by addressing past experiences. Enablers included the PNM's focus on strengths, its support of collaboration, and its accessibility. Strategies to assist in 'selling' and embedding the PNM in services were elucidated, including strategies to collaborate meaningfully with service users and support the risks presented through the development of narrative as well as its facilitation in services through continuous on-site support.

1.5 Positionality

I am a white, female, non-professional, junior researcher from Canada who came to this research with very little knowledge of or exposure to either inpatient mental health services or the active and debate-fraught world of mental health 'behind the curtain' of mainstream understanding. My journey towards alternative understandings of mental health and beginning to question conventional knowledge has been a large and important part of my PhD process. The position I landed on seeks to move beyond binary understandings of mental health and its attendant ideological debate to the position that whatever approach is helpful for an individual, service user, patient, carer, or family and the professional with whom they work is likely the 'right' one. Similar to the Foucauldian post-structuralist approach to critique taken up by prominent critical suicidologists (Foucault, 2019; White & Morris, 2019), the approach here, in line with critical realism, is that services should work alongside service users to identify 'what works, for whom, and in what circumstances' (Tikly, 2015).

1.6 A Note on Language

I will be using recovery-based language to refer to those who access services while acknowledging there is a lack of consensus about what is considered inclusive language. 'Patient' has been contested, as has 'survivor'. 'Service user' is not without criticism either

(Simmons et al., 2010) but is the most commonly employed term for individuals I refer to throughout this research (those who are accessing or 'using' services). Thus, 'service user' is this term I use, which aligns with the uneasy compromise taken by others (Faulkner, 2017). Those participants recruited outside the mental health system are referred to as having 'lived experience' (of mental health challenges). I also endeavour to use less clinical or medical terminology, both in alignment with a more psychosocial perspective on how best to understand mental health, but also to make this research more widely accessible to readers. For example, instead of 'mental illness' I use the term 'mental distress' or 'mental health challenges,' while again acknowledging the imperfect use of these terms (Pilgrim, 2020).

The use of the term 'positive practice' throughout this research is an attempt to encapsulate the widely reported features of practice experienced positively by service users and staff (see Chapter 2), including but not limited to those related to 'personal recovery' (Slade, 2009), 'trauma informed practice' (Sweeney & Taggart, 2018); SDM (Slade, 2017); and PRT (Stickley & Felton, 2006). Thus, it should be understood as a broad term not to be attached to any one of these approaches in particular.

1.7 Organisation of the Thesis

Within this first chapter, I introduced the research, including the aims, research questions, major findings, and contributions. I have described the context of this research, including the setting's cultural transformation which provides the cradle for this research. I have included a self-reflection which positions me within the research, and I explained my approach to language.

Chapter 2 presents the literature review. This is the first of two chapters to convey the current state of relevant research and to identify existing gaps; this is in line with the approach taken by Kent (2011) and Nicholson (2018) to address topics at 'strategic points.' This chapter focuses on the topic of 'positive practice' for staff and service users within inpatient settings, as well as the barriers to these practices. Specific practices that support positive experiences are explored, including SDM, PRT, and psychological formulation.

Chapter 3 describes the approach to methodology. The research aims and research questions are restated, which provide a justification for the methodology and methods selected for this research. Mixed methods and case study approaches are separately explained, as is the Mixed Methods-Case Study (Guetterman & Fetters, 2018). The methods are explored in turn, as are data analysis and ethical considerations.

Chapter 4 accounts for the theoretical framework adopted for this research (critical realism) including the epistemological and ontological positioning taken. Patient and Public Involvement (PPI) is described, as well as the SUAG and their involvement throughout this research.

1.7.1 Stream 1

Chapter 5 entails an account of Poppy ward staff interviews and their account of good practices. The main themes developed included (a) 'really, really good' relationships, (b) culture of empowerment, and (c) team support and development.

Chapter 6 entails an account of Poppy ward service user interviews relating to their views of good practices. The four main themes the group developed were (a) shared responsibility and power; (b) everyone takes care of each other; (c) staff are uniquely skilled and experienced and (d) a healthy and helpful place.

1.7.2 Stream 2

Chapter 7 describes a literature review of psychological formulation, conducted to identify the strengths and gaps of existing research on psychological formulation. A description of the development of the PNM, beginning with a rationale for its development followed by its philosophical foundations is provided along with an account of influential documents. The Power Threat Meaning Framework (PTMF; Johnstone et al., 2018), which had a particular influence on the development of the PNM is described at length and an account of common critiques is provided as well as rebuttals. Iterations of the PNM, including a description of specific recommendations for amendments is provided, as is the final Model and a description of its components. The chapter concludes with a description of the Poppy ward staff training on the PNM.

Chapter 8 conveys the results of the Poppy ward staff focus group, which followed the staff training. The four themes developed included (a) strings left untied; (b) meet staff where they are at; (c) PNM could add meaning and coherence; and (d) the proof of the pudding is in the eating.

Chapter 9 conveys the online acceptability study with its online survey and interviews. Quantitative findings are reported and include an identification of risks which are explored through the qualitative results. Qualitative acceptability findings involved the development of four themes: (a) a warm welcome to alternatives to the biomedical model; (b) the PNM's legitimacy; (c) predicted practical utility of the PNM; and (d) PNM as inclusive but unproven. Implementation of the PNM involved the development of five themes,

including (a) embedding through training; (b) resistance as default; (c) what hinders and helps collaboration; (d) narrative and talking about past events is distressing; and (e) possible applications and adaptations of the PNM.

Chapter 10 presents the discussion, which describes the key findings of the research, how they relate to the wider literature, the contribution to knowledge offered by this research, its practical and clinical implications, limitations, and suggestions for future research.

2. Chapter 2 Literature Review

2.1 Chapter Overview

In this chapter, I begin by addressing the protocol I adopted for searching the literature for relevant research. I subsequently explore the questions, (a) 'What does positive practice in the inpatient setting look like?' (b) 'What specific practices/orientations are thought to promote positive practice?' and (c) 'What are the barriers to positive practice?' The literature addressing the first question involved themes relating to good relationships, the role of relationships in minimising the use of coercion, the importance of collaboration, and safety. Themes relating to answering the second question included recovery, psychological formulation, SDM, and PRT. Themes developed in answer to the third question involved coercion and its experience as well as its negative consequences, service user violence, involuntary care, overburden of staff, overburden of limited resources, and limited therapeutic engagement. A section on how BPD care aligns and differs from the rest of the literature is offered. The chapter concludes with a synthesis of the gaps identified in the literature.

2.2 Search Strategy

To address the questions asked within this literature review, an initial scoping search of Google Scholar was performed, the results of which guided the development of each topic and subtopic detailed below. Following topic identification, PsycInfo, Medline and CINAHL were further consulted. Search terms employed included, "mental health," and "inpatient" or "acute" combined with the topic term, for example, "relationships". Searches began with 'systematic review' or 'review' with preference given for literature relating to inpatient experiences; however, other settings deemed relevant were also consulted and where they are included, this is noted. Reference lists of articles included in the review were additionally cross-referenced for other relevant articles. 'Grey' literature was consulted and included where relevant, and the Clinical Psychology Forum was searched separately as articles published there do not typically emerge from standard database searches. Preference for evidence from the UK was given; however, literature from other Western countries deemed relevant were included given their similar cultural views towards mental health and the operation of mental health services. Countries of research origin are noted where relevant.

2.3 What Does Positive Practice in the Inpatient Setting Look Like?

2.3.1 Good Relationships as Valued Part of Inpatient Care

2.3.1.1 Relationships Important for Positive Experiences for Staff and Service Users. In existing studies, positive experiences of treatment for both service users and staff appear to hinge on the relationships they experience with others. The importance of the relationship between staff and service users has been noted, particularly by Peplau (1952), whose Interpersonal Relations Theory recognised relationships as foundational to nursing practices. The relationship between staff and service users is sometimes more formally operationalised as 'therapeutic alliance' or the 'therapeutic relationship' and is somewhat interchangeable in the literature with staff-service user relationships more broadly, making the distinction of the two (if one exists) murky. The 'therapeutic relationship' itself is ambiguously defined (Moreno-Poyato et al., 2016).

In two recent systematic reviews, Wood and Alsawy (2016) as well as Woodward, Berry and Bucci (2017) found positive experience of relationships plays an important role in treatment satisfaction. Staff supportiveness and accessibility were found to be highly related to satisfaction, with relationships with nurses yielding the highest rates of satisfaction for service users (Woodward et al., 2017). Beyond satisfaction, McAndrew and colleagues (2014) as well as others (Priebe et al., 2011; Hewitt & Coffey, 2005) argue the development of therapeutic relationships precedes beneficial outcomes for service, including treatment effectiveness (Berry et al., 2012; Marziali, 1984).

Stapleton and Wright's (2019) meta-synthesis indicated the most prevalent theme discussed by service users with a diagnosis of BPD in relation to what features of the inpatient experience are important is contact with staff and fellow service users. This theme was characterised primarily by the opportunity to talk and be listened to; Acford and Davies (2019) similarly found services users with a diagnosis of BPD emphasise positive relationships with staff in inpatient care. Being denied the opportunity to talk with staff was experienced as unhelpful, a relatively common experience on inpatient wards.

In their exploration of whether contact with services is helpful for service users with a diagnosis of BPD, Morris and colleagues (2014) found a key determinant is that 'it's all about the relationship,' which was echoed in Gillard and colleagues' (2015) interview-based study relating to 'understanding recovery in the context of lived experience of personality disorders' which utilised a collaborative piece of research alongside consumer researchers jointly involved in conducting interviews and analysing data. Morris and colleagues (2014)

indicated that because interpersonal difficulties form the central core of distress for many service users with a diagnosis of BPD, the major goal of care should be to support service users to develop a positive relationship with staff. Gillard and colleagues (2015) expanded their conceptualisation of relationships to include both positive personal relationships and broader social interaction. While Gillard and colleagues (2015) emphasised the need for services to provide space in which positive relationships can be nurtured, Morris and colleagues (2014) reported participants felt that many staff were either unable or unwilling to dedicate the requisite time for this to occur.

The importance of the therapeutic relationship has naturally led to an interest in measurement and standardisation. However, as Moreno-Poyato and colleagues (2016) and others (Cahill et al., 2013; Cameron et al., 2005) have argued, relationships are built in a multitude of ways using a variety of therapeutic modalities and interventions. Service users and staff will also have varying needs and preferences, making standardisation and measurement a 'thorny issue.' However, trust and respect, described below, are specific qualities service users value, and may be integrated and supported through standardised practices, training, and, possibly, specific models.

2.3.1.2 Comparing Staff and Service Users' Perspectives of Relationships. In a review of therapeutic engagement in acute inpatient wards, McAndrew and colleagues (2014) indicate that for mental health nurses to provide 'sensitively attuned nursing care,' staff need to develop the therapeutic relationship. This supports service users to share their experiences and adequately contextualise their distress. To facilitate the development of this relationship, service users value positive attitudes, feeling listened to, and feeling that staff are trustworthy. Mental health nurses feel similarly, although with a greater focus on skills. Staff emphasise their ability to talk, listen and demonstrate empathy. A common thread appears to be staff's ability to listen to service users in an authentic way. Forty-eight articles were included in Moreno-Poyato and colleagues' (2016) narrative review, through which the authors found service user and staff members' experience of relationships are fundamentally similar, although barriers are experienced somewhat differently. For example, limited time for service users leads to feeling undervalued, while for staff this is the result of administrative demands and overwork (see Section 2.5.6).

2.3.1.2.3 Relationships in Averting or Minimising Impact of Coercion. Much of the role of staff-service user relationships has been discussed in the literature as it relates to the use and/or impact of coercion. In their UK-based study, Rose and colleagues (2015) described nurses and healthcare assistants (HCAs) identifying relationships as diverting coercion.

Quality relationships between staff and service users was suggested to avert the use of restraint by improving safety (Henderson, 2014); further, the results of two recent systematic reviews (Aguilera-Serrano et al., 2018; Chieze et al., 2019) found that positive relationships may moderate the impact of coercive interventions when they are employed. Aguilera-Serrano and colleagues (2018) found that the sharing of information alongside interaction with staff influence the subjective experience of coercive interventions. Humane treatment, staff support and respect for the person were associated with a better experience; debriefing was also viewed as an important process. This finding was echoed by Akther and colleagues' (2019) systematic review, who found staff who were perceived as attempting to develop collaborative relationships with service users, as well as the provision of information, cushioned the negative impact of involuntary care regardless of the coercive inpatient context.

2.3.2 Features of Good relationships: Recognition of Humanity; Trust and Respect

In Staniszewska and colleagues' (2019) systematic review, trust and respect were critical to positive experiences and for feeling safe in the ward environment. However, some research has indicated the difficulty of establishing trust in the inpatient environment, such as that by Hem and colleagues (2008), whose Norwegian-based study involved six service user interviews, observation and a case study. Their case study of a service user who experienced detainment portrays the staff-service user relationship founded on 'mutual distrust,' with staff "barricading themselves in the nurses' station' which escalates the service user's distress given their obvious lack of trust" (p. 785).

In a mixed method study involving questionnaires and focus groups, Gould (2012) collected data from 81 service users relating to their experience of recovery. Gould found staff's professional qualities were considered by service users to be at least as important to recovery as treatment and included qualities such as respect, compassion, and honesty; in other words, humanity.

In a 2017 systematic review involving 26 studies, of which seven were based in the UK, Tingleff and colleagues found service users' perception of being treated respectfully by staff determined their assessment of coercive experiences as positive or negative; they also appeared to view a lack of respect as causing behaviours that may lead to the use of coercive interventions. Trust has been suggested to possibly replace risk in meeting the needs of service users (Brown et al, 2009) and has been deemed necessary for the promotion of therapeutic engagement. Akther and colleagues (2019) similarly indicated staff who showed respect for service users were spoken of positively while those who were disrespectful induced feelings of 'anger, betrayal and abandonment.' Similar findings were described by Goodwin and colleagues (1999), whose interviews with 110 inpatient service users in rural England indicated that some individuals felt that a lack of respectful treatment formed the core of their difficulties and that within the inpatient ward environment especially, a 'mortification of self' can occur where typical processes of self-determination and freedom are stripped.

The promotion of therapeutic engagement (in contrast with the barriers described below) can be promoted through the recognition of humanity. In their study of staff experiences of therapeutic engagement with service users with a diagnosis of BPD, Acford and Davies (2019) described how during two of the four focus groups, team-level psychological formulations (Johnstone, 2014) were described as important for staff knowledge of service users' histories and ultimately feeling more understanding, empathetic and compassionate towards service users who had undergone a formulation. This finding raises questions relating to the specifics of the formulation meetings, which were not discussed (for example, whether service users participated). These findings also raise important questions relating to the possible role of formulation in enhancing empathy for service users, particularly given the suggestion that it may increase empathy within staff working with service users who have been reported to inspire 'therapeutic nihilism.'

2.3.3 Collaboration as Valued Part of Inpatient Care

The importance of collaborative care in promoting positive experiences of inpatient services has been reported by both staff (Boardman et al., 2018) and service users (Staniszewska et al., 2019), with particular emphasis by service users. In Wood and Alsawy's (2016) systematic review, one of the three superordinate themes described is collaborative and inclusive care. The authors indicated the degree of influence exerted by service users

over their care or treatment plan directly impacted on their recovery. In reality, 'the majority' of service users reported a lack of meaningful involvement in their care plans, leading to a sense of powerlessness (Wood & Alsawy, 2016). This is echoed in a systematic review by Bee and colleagues (2008) which found few studies demonstrating evidence of collaboration between service users and staff. Interestingly, Wood and Alsawy (2016) found for some participants, the opportunity to make decisions introduced trepidation or pressure to make the 'right' decision.

A researcher with lived experience of inpatient services, Sheldon (2011) argued that a common experience of care is 'being done to' with few opportunities for meaningful engagement, although she indicated this was starting to change. Sheldon was emphatic that the end-goal of full engagement is a right of which we should not lose sight. In reporting her findings of a survey conducted with a Service User Reference Panel, Sheldon argues that those who felt most positively about their care also knew most of the relevant details and were involved in the process. Thus, while an argument for collaboration based on effectiveness exists, it is also a moral matter.

Part of the difficulty of collaboration is perhaps that many processes in the psychiatric setting have not traditionally involved service users; also, current methods possibly do not provide specific guidance on how best to go about involving service users. For example, many psychological formulation models do not provide suggestions on how or when to involve service users, leading to an idiosyncratic approach for most professionals. Thus, it is possible that models which provide specific best practice suggestions may facilitate increased rates of collaboration.

2.3.4 Safety as Valued Part of Inpatient Care

Safety represents the positive, reverse side of coercion. Recent research reveals a lack of existing knowledge as it relates to safety in inpatient settings. Berzins and colleagues (2018) argue that establishing priorities for inpatient service user safety has "received less international attention than in other areas of health care" (p. 1085). Thibaut and colleagues (2019) concurred, presenting the "first review to examine patient safety within inpatient mental health settings that uses robust systematic methodology" (p. 9). The authors' systematic review involved 364 studies (102 UK); 45% included staff and 33% included service users, with the remaining 21% involving a mixture of staff, service users and/or carers. Thibaut and colleagues (2019) developed 10 research categories, including the

interpersonal violence and coercive interventions described below. A third category, safety culture, was found to comprise of staff stress and burnout as well as communication, described above.

Overlapping somewhat with the relationship category described above, which effectively prevents or cushions the impact of coercive interventions, is the safety provided by relationships. Berzins and colleagues (2020) reported findings from interviews with service users and staff relating to their perspectives on safety issues in UK mental health services, arguing the relationship between staff and service users as it relates to safety (as opposed to care quality) was not often considered, although their study's findings suggested a strong association. Bacha and colleagues (2019) found in their interview-based study of with eight service users from northern UK, participants' experience of relationships with staff was helpful and transformative on the condition that relationships were empowering, supported personal identity, and were safe. Thus, safety may have a bearing on the quality of the relationship.

Safety was one of the eight themes developed by Gilburt and colleagues (2008) in their Participatory Action Research (PAR) design involving user-led interviews of 19 service users who had experienced psychiatric stays in London. Safety was conceptualised as safety from both others as well as the self. Similarly, Stenhouse (2013) looked at service users' perceptions of safety in an acute psychiatric inpatient ward in an interview-based study involving interviews with 13 service users from a large psychiatric hospital in an urban-rural area of Scotland. The ward was seen as 'safe enough' by some participants. Participants conveyed the expectation their environment would keep them safe from both suicidal impulses as well as the outside world. In contrast, in their study of 17 service users from four inpatient settings in Sweden, Pelto-Piri and colleagues (2019) found that service users "stressed the importance that you, as a patient are *taking responsibility* for your own rehabilitation" (emphasis in original; pp. 5-6) and thus, the ward environment cannot be expected to maintain service users' safety without their active participation.

Service users and staff view service user safety differently. Two recent studies explored this phenomenon, including a co-produced, UK interview-based study of 23 service users, 46 'stakeholders' and practitioners and over 700 Twitter responses by Carr and colleagues (2019) and an online open-ended questionnaire involving 93 participants from 12 countries including five groups of participants (healthcare practitioners, service users, researchers, carers and other 'stakeholders') by Tyler and colleagues (2020). Carr and colleagues (2019) found while staff understandings of risk and vulnerability more commonly

"focus on 'mate crime', coercive control by family and financial abuse" (p. 789). Service users view mental health services themselves as sources of risk and increased vulnerability to violence. In Tyler and colleagues' (2020) study, staff and researchers tended to emphasise traditional safety indicators (for example, suicide and self-harm) while service users and their families viewed safety more broadly, including emotional, social, and behavioural safety (for example, loneliness, emotional readiness for discharge) as well as inter-professional communication relating to care. This divide is echoed by Berzins and colleagues' (2020) findings, where carers indicated primary concern with service users' physical safety where service users were concerned with both their physical and psychological safety, and where service users often felt their physical safety was protected at the expense of their psychological safety.

2.3.5 Summary of 'What Does Positive Practice in the Inpatient Setting Look Like?'

Relationships between staff and service users are important for staff and service users' experience of the ward, playing a role in both satisfaction and outcomes. Relationships are also important features for service users with a diagnosis of BPD, possibly even more so given that interpersonal difficulties form the core of many individuals' mental health difficulties. While staff and service users both emphasise the therapeutic relationship, the features they value are slightly different: service users value positive attitudes and feeling staff are trustworthy while staff value their own ability to talk and listen as well as demonstrate empathy. Barriers to the development of relationships (e.g., paperwork) are experienced by service users as a rejection while for staff this is a frustrating but essential part of their job. Trust and respect between staff and service users may be important for both the development of relationships as well preventing coercion. There is evidence this trust is difficult to develop in an inpatient environment; however, the practice of psychological formulation may improve staff understanding and empathy for service users which can be important when working with service users with a diagnosis of BPD. Service user involvement in care is supported by both ethical and practical arguments and yet there is little evidence of its being consistently or meaningfully practiced in the acute mental health setting. Safety is under-researched but an important antidote to the fear posed by coercive practices. Both staff and service users indicate a fear for their safety, although staff tend to fear physical harm while services users believe their physical safety is preserved at the expense of their psychological safety. Relationships are seen to provide safety, as does a

therapeutic environment. Psychological formulation may help with development of trust, empathy, understanding, enhanced collaboration, and overall better relationships.

2.4 What Specific Practices/Orientations are Thought to Promote 'Positive Practices'?

'Positive practices' here encompasses best practice, person-centred practices, recovery-oriented practices as well as SDM and PRT (see Chapter 1).

The review has thus far highlighted that while factors associated with positive experiences of care are known to researchers and mental health services alike, a multitude of barriers to implement these practices exist and negative or unhelpful experiences of care are unfortunately too common. Specific approaches to support both staff and service users to improve experiences of care as well as achieve better outcomes have been identified. These are aligned with principles of recovery-oriented practice, person-centred care, SDM and PRT.

2.4.1 Recovery

Neither recovery-oriented practice nor indeed person-centred care have achieved a definitive shared understanding (Le Boutillier et al., 2015). Various settings, contexts, professional identities, and other users of services may hold varying ideas of what recovery-aligning care means to them. At its core, recovery-oriented practice entails a shift from focusing on symptom relief or 'clinical recovery' as the target of treatment to valuing an individual gaining a 'meaningful and satisfactory life by promoting hope, attainment of personal goals, social inclusion, and supportive relationships' (Waldemar et al., 2016, p. 596). Waldemar and colleagues (2016) argued while more is known about the implementation of recovery-oriented practice in community or other outpatient settings, its implementation in acute services is relatively uncharted.

Gyamfi and colleagues (2020) conducted a systematic review relating to knowledge and attitudes of both mental health professionals as well as students relating to recovery. The review included 29 qualitative, quantitative, and mixed methods studies (4 Ireland, 3 UK, 1 Wales). The authors found evidence of an increase of knowledge, attitudes and expectations relating to recovery. They also described how recovery-promoting interventions yielded improvements in idea-sharing and peer support. However, there was an observed disparity in understandings of recovery as a personal versus clinical process; an awareness of the non-linearity of the recovery journey was also poorly demonstrated in the literature reviewed.

Waldemar and colleagues (2016) also conducted a literature review of inpatient mental health settings' approach to recovery. Eight studies were included in their review (one UK, one Ireland). Like Gyamfi and colleagues (2020), the study's findings indicate that services' definition of recovery "comes across as vague and sometimes contradictory" (p. 599) with some participants framing their understanding through the traditional biomedical model while others as 'personal recovery' (Waldemar et al., 2020), and this divergence is echoed in views relating to implementation. While it is argued that recovery-promoting ways of working are, in fact, less resource intensive: "good risk management, therapeutic relationships, meaningful activities, attention to physical health and social inclusion all promote recovery and are cost- effective" (Baker at al., 2014, p. 18) and an overwhelming majority of staff indicated they were supportive of the concept and intended to implement it, staff spoke of difficulties applying their knowledge of recovery in everyday practice. Poor communication and lack of involvement in the development of care plans were prevalent, and staff indicated an awareness that the level of service user collaboration did not meet their own hopes and expectations. Barriers identified included limited resources such as high bed turnover as well as too few beds, increasing levels of distress, and unpredictable events. In describing the limited implementation of recovery-oriented practice in acute inpatient settings, Waldemar and colleagues (2016) raised the question of "whether recovery-oriented practice can or should be an approach used in these settings" (p. 596) given the significant and seemingly unavoidable barriers present.

In a Belgian study, De Ruyssher and colleagues (2020) also sought to address the gap identified by Waldemar and colleagues (2016), exploring the implementation of recovery in the acute inpatient context. Ten staff members and 10 service users participated in the study. The results of this study are more hopeful; the ward environment is reported to serve the function of asylum. Within this context, psychiatric diagnosis does not play a formative role in recovery. The role of the ward was seen to introduce the 'outside world' to inpatient service users in stages. Speaking about the outside world while in the ward and involving family, for example, reduces the sense of 'false dichotomy' that may otherwise result: the ward as 'safe and protected' and the outside world as 'dangerous and unmanageable.' Although the authors discuss barriers to the recovery orientation, such as 'hospitalisation syndrome' (institutionalisation) and discharge often being based not on service users' readiness to leave but the availability of housing, the strong links with recovery orientation and positive experiences of the participants suggests, at least in this particular context, recovery-aligned services are possible.

2.4.2 Psychological Formulation

Formulation has traditionally been a core skill for psychologists and is included both in training programmes and the key skills listed in official practice guidelines by the Division of Clinical Psychology (DCP; DCP, 2001). Variations of formulation are now included in the training of other mental health professionals, such as mental health nurses; the Royal College of Psychiatrists deems case formulation an essential competency (2010). Formulation has recently been listed one of the 18 core competencies in the Mental Health Core Skills Education and Training Framework (2017). There is no universally agreed definition of formulation. A generic definition offered by Levenson and Strupp (2007) is that psychological formulation is a hypothesis of the causes, precipitants, and maintaining factors implicated in a person's social, psychological, and behavioural dysfunctions. According to Butler (1998), most therapeutic orientations can agree that formulation is a "lynchpin that holds theory and practice together," (p. 2). The main purpose of a formulation is often seen to establish the correct treatment strategy (Onyett, 2007).

Formulation has not been studied extensively in the inpatient setting, although an evaluation in 2016 by Berry and colleagues indicates it is feasible to implement psychological formulation in a psychiatric inpatient context, thus supporting the implementation of the current research. Existing research exemplifies the function of psychological formulation in the context of a personality disorder service. A service user with lived experience given the pseudonym 'Kath' describes how her experience of formulation "produced a document that encompassed me…The guided formulation made what has always seemed illogical, logical ... It gave my feelings validity and helped me to see myself as a whole rather than fragmented pieces… It really wasn't all my fault, and now I had the proof." (Yeandle et al., 2015, p. 28). Promoting a whole-person view aligns with that described by the recovery approach. See Chapter 5 for a more in-depth exploration of the psychological formulation literature and theory.

2.4.2 Shared Decision Making

Arguments relating to the use of SDM can be parsed into those relating to its efficacy and its morality. Relating to the morality argument, Sheldon (2011), Castillo and Ramon (2017), and others argue that service users want and are owed the opportunity to collaborate with staff on their care, yet this is something they are seldom granted (Zisman-Ilani et al.,

2021). Collaboration aligns with the survivor slogan, 'nothing about us, without us' and follows the lead of physical health care. Mental health care possibly presents a stronger case for collaboration given the deeply personal nature of mental health difficulties and the possibilities for power differentials in mental health services. The separate but related question raised by Cutcliffe and Happel's (2009) research question, 'Can mental health nurses operate in a way that is genuinely focused on power-sharing in a system or governmentality that is built on propagating this power?' varies depending on who is asked. A recent study (Luciano et al., 2019) indicates that service users with a higher level of skill in interpersonal relationship and global functioning may respond more favourably than their counterparts.

The question of the practicality or efficacy of SDM forms the second arm of research. Relating to efficacy, results vary. A Cochrane review by Duncan and colleagues (2010) was inconclusive regarding the impact of the use of SDM on outcomes. UK-based Thompson and McCabe (2012) conducted a systematic review to address the impact of clinician-patient alliance and communication on mental health care treatment adherence. Twenty-three studies were included (countries of origin were not shared). The authors attended to SDM given its emphasis in policy relating to collaborative communication. The authors found that the evidence to support SDM is inconsistent even when the preference for the degree of involvement is met by service users. The impact of SDM on adherence in experimental studies is also not straightforward, with mixed results; positive effects may be explained by other factors outside of SDM itself.

A recent Norwegian study by Beyene and colleagues (2018) explored the question, "what are prerequisites for mental health professionals to practice SDM in a therapeutic milieu?" (p. 1). Focus groups were conducted through clinical supervision; eight staff members, seven of whom were nurses, participated. One overarching theme was developed: 'practicing SDM when balancing between power and responsibility to form safe care,' which was characterised by a perceived constant balancing act on the part of the clinician, where although both the practitioner and service user are seen to share responsibility for SDM, practitioners nevertheless 'take charge' until the service user is "no longer in danger for oneself or others" (p. 5). The authors found a 'culture of trust' results from person-centred care and "standing together as a team" (p. 4).

Castillo and Ramon (2017) investigated the SDM experiences of service users in a review of 17 studies (eight UK-based and one multi-country study including a site in the UK). Service users were found to hold mixed views of the involvement of lay supporters in

decision-making; 67% of papers highlight issues of perceived risk affecting SDM while in an overwhelming majority (89%) of cases, trust and the therapeutic relationship were emphasised by both service users and professionals as required conditions under which SDM can be applied. The authors also found a difference of opinion relating to respect where practitioners believed they were already working in a respect-led way while 67% of service users reported mistrust of practitioners along with a lack of involvement (67%). High rates of perceived power imbalance were also highlighted.

2.4.3 Positive Risk-Taking

PRT "involves empowering patients to make decisions regarding their own safety and to take risks to enable personal development… it involves patients making choices and having control… Therapeutic risk-taking is underpinned by recognition that risk is not solely defined in terms of harm, hazards and danger. Risk can also create possibility, opportunity, and achievement" (Felton et al., 2017, p. 81; Morgan, 2004)." PRT is one of the core values included in the Department of Health's Essential Shared Capabilities Framework (Department of Health, 2004).

In the context of inpatient services and its disempowering structure and processes, PRT has been argued to empower service users to make decisions about their lives and to accept a degree of risk, which, it is argued, is fundamental to human dignity (Marsh & Kelly, 2018). It has been argued that PRT empowers service users by emphasising their responsibilities as opposed to their willingness to conform, and, in doing so, shifts the orientation of care from protectionism to that of promotion of autonomy and liberty (Stickley & Felton, 2006). In this way, PRT principles are closely tied to those of recovery. It should be noted the integrity of the concept of 'empowerment' within the psychiatric context has been questioned due to the position of power being retained by the practitioner who, in practicing PRT, endows power upon the service user, thereby reinforcing the existing power dynamic (Stickley, 2006) but is nevertheless viewed as a step towards more democratic ways of working.

Stickley and Felton (2006) argue mental health nurses have a duty to evaluate risk; however, they argue that due to protocols and wider organisational stances towards risk, 'defensive practice' has become mainstream. This is argued to limit mental health recovery given that risk-averse care serves not the interests of the individual but those of the organisation (Beck, 1999). Stickley and Felton (2006) indicate that "any attempt at promoting

recovery involves a shift in power position" (p. 29), which would occur through the acknowledgement of the service users' expertise in their own lives. Thus, PRT, by virtue of empowering service users to take growth-promoting risks, is essential for recovery (Stickley & Felton, 2006). Marsh and Kelly (2018) argue that beyond promoting recovery, risk-taking is a fundamental condition for human dignity.

Reddington's (2017) review suggests research relating to PRT is limited, highlighting gaps in existing research as well as making recommendations regarding how PRT can influence practice. Her review revealed the multifarious ways risk is viewed and argues the NHS National Standard (NHS QIS, 2005) falls short in not providing more clarity on how to provide a 'safe and effective service' which is often interpreted in a way that results in over-management or concentration on risk as opposed to supporting service users' control over their own lives. Reddington (2017) argues that a recovery-oriented approach (supported by the NHS) should involve PRT, which, in turn, requires high quality risk management. Reddington (2017) and Davis (1996) argue seeing service users as whole people is necessary for good risk management. An individualised understanding of risk, what this means to various service users, and an appreciation that this may differ from staff conceptualisations of risk is also required.

Just and colleagues (2021) investigated staff views towards PRT in acute settings through interviews with 16 inpatient staff working in three NHS Trusts in the North-West of England. Two of the three main themes were barriers to PRT which were organised into staff and service user barriers. The third theme was delivery in practice. Barriers related to staff included their use of diagnosis as the basis of their risk management as well as the fear of accountability should adverse events occur because of these management decisions. Uncertainty and lack of familiarity with PRT were barriers for more junior staff while complacency deterred more senior staff. Relating to service user barriers, only service users with a low level of staff-perceived risk were considered eligible for PRT; staff also felt PRT requires trust between themselves and service users but that this trust was difficult to establish. Finally, delivery in practice encapsulates the enablers and barriers of the implementation of PRT. All participants indicated they intended to implement PRT but struggled to do due to administrative demands in addition to a perceived absence of peer support. The authors indicated staff appeared to conflate collaboration and imposing their own ideas of the best way forward (for example, valuing the input from friends and family in risk-planning but not incorporating these perspectives meaningfully in the resulting risk plan).

2.4.4 Research on Positive Practice

While much of the evidence discussed indicates poor experiences of acute inpatient services, or at least a host of challenges to positive experiences, still some studies have found instances of service user and staff satisfaction. Wood and Alsawy's (2016) systematic review indicated the importance of noting that some service users reported feeling supported by staff and safe on the ward. Berzins and colleagues (2018) indicated several service users had experienced good relationships with a handful of staff, and this was echoed by Lilja and Hellzén (2008) who found care "can sometimes be seen as a light in the darkness" (p. 283). Gould (2012) reported similar findings but hedged there is still a "considerable way to go" (p. 11).

A few authors have explored examples of positive practice specifically; for example, Pereira and Woollaston (2007) identified eight 'positive practice' psychiatric admission units through use of a steering group and collected data regarding therapeutic activity through multidisciplinary focus groups. Examples of their good practice included multidisciplinary staff being accessible to patients (for example, the nurses' office door was 'always' open) and spending a large amount of time with service users (for example, HCAs were with the service users 'all the time'). However, the study describes only the experiences of staff and service users on general adult acute psychiatric wards, which may not reflect the experiences of individuals with a diagnosis of BPD or those who work with them.

In addressing examples of positive practice in the context of services providing care for service users with a diagnosis of BPD specifically, Acford and Davies (2019) identified a lack of 'positive' and 'what works' research relating to how non-specialist staff engage with service users with a diagnosis of personality disorder. Their results illustrate the continuing difficulty of employing positive practice in an environment that constantly challenges them: staff casually (and in a somewhat normalising manner) described instances of service users 'slapping' them; widespread anxiety regarding risk-taking; and as the authors pointed out, there was no mention of establishing or maintaining rapport. The findings pointed strongly to participants feeling a lack of specialist training and the authors concluded this training should emphasise service user collaboration and provide a clearer theoretical basis for areas of practice that were described, though not named, by participants (for example, selective disengagement and structured care-planning). This leaves a gap for research to investigate a context in which these practices take place.

2.4.5 Summary of 'What Specific Practices/Orientations are Thought to Promote 'Positive Practices'?'

There is a dearth of research relating to recovery practices in acute mental health settings, and the limited research which does exist indicates mixed results. This has led some researchers to question whether recovery-based practices can or should be used in acute settings. Psychological formulation has been suggested as a possible means of forwarding the person-centred agenda proposed by recovery research, and this is supported in the extant, albeit scant, research in acute settings (see Chapter 7). The research on SDM indicates few studies robustly support the helpfulness of SDM, although some research indicates staff can apply it and service users can verify it is more than mere rhetoric. Further research is needed to clarify its helpfulness and application. A strong case for PRT has been made through an ethical lens; however, little research exists to support its practice in an acute setting. There is little research on positive practice in an acute setting generally, which should be addressed.

2.5 What are the Barriers to Positive Practice?

In seeking research on positive practices, I instead observed numerous accounts and descriptions of barriers to achieving positive practices, both from the perspective of service users as well as staff. In the following section of this literature review, I attempt to categorise and outline these barriers, which include coercion (restraint and seclusion as well as involuntary care); overburden of staff; overburden of services; and subsequent scarcity of therapeutic engagement.

2.5.1 Coercion as Barrier to Positive Practice

The clinical benefit of the use of coercion remains dubious, as demonstrated by Newton-Howes and Mullen (2011), whose systematic review of 27 articles based in Europe (countries unspecified) revealed the absence of consistent outcome measures, inconclusive quantitative results and provides insufficient evidence by which to form any conclusions. Multimodal interventions have been devised internationally to minimise the use of restraint. Those developed or adapted for use in the UK, for instance, Safewards (Bowers et al., 2014) and REsTRAIN YOURSELF (Duxbury, 2016) have resulted in the successful reduction of restraint (Bowers et al., 2015; Duxbury et al., 2019). Despite this, coercive practices remain in use (Agenda, 2017; MIND, 2013). A recent systematic review (Staniszewska et al., 2019)

examining service users' experiences of inpatient mental health services (Staniszewska et al., 2019) found coercion to play a major role in experiences. This review was large-scale, including 72 studies from 16 different countries (one-third of which were UK-based). The findings, analysed using a qualitative approach, indicated service users view coercion to be, at least at some level, unavoidable. This somewhat aligns with Wilson and colleagues' (2017) findings of restraint being viewed as a 'necessary evil'.

A systematic review and meta-analysis including 31 studies from high-income countries (5 UK, 1 Ireland) by Iozzino and colleagues (2015) framed violence as internally explained by service users: the objective of the study was to review service user characteristics as well as factors related to studies that could explain the variation in rates of service user violence. Statistically, the authors found male, involuntary, alcohol dependent service users with a diagnosis of schizophrenia and a history of violence related to higher rates of inpatient violence (these factors accounted for 68% of the study heterogeneity). Wider contextual or environmental factors were not included in the analysis. Similarly, in their South London study of both service users (n = 37) and staff (n = 48), Rose and colleagues (2015) reported that amongst views of experiences of acute mental health settings, coercion was one of two main themes, although service user and staff perspectives differed such that while service users attribute the use of coercion as a consequence of behaviour they felt they were 'driven' to, staff believed their use of coercion was the natural result of 'internally' fuelled behaviour on the part of service users.

2.5.2 Experiences of Coercion

Two systematic reviews (Aguilera-Serrano et al., 2018; Newton-Howes & Mullen, 2011) explored experiences of coercion from service users' perspectives. The results of both reviews illustrate an overwhelmingly negative experience of coercion for service users based on a qualitative synthesis of quantitative, qualitative, and mixed methods data. For Newton-Howes and Mullen (2011), themes included feelings of disrespect and not having a voice; among the most common experiences was feeling dehumanized, which aligns with findings from other UK-based research (Wilson et al., 2017). Aguilera-Serrano and colleagues (2018), whose review included 34 international studies (2 of which were based in the UK), also reported most negative experiences with coercion, although they also discussed some data in which some positive experiences had been reported (for example, the belief of its use preventing further violence). A minority of positive experiences is reflected elsewhere in the

literature, perhaps based on environmental or contextual factors such as relationships (Chieze et al., 2019; Tingleff et al., 2017). In their systematic review, Akther and colleagues (2019) found small gestures from staff, such as checking in on them during restraint, can moderate the negative impact of coercive interventions.

2.5.3 Negative Consequences and Trauma

Specific deleterious effects of the use of coercion for service users were explored via a systematic review by Chieze and colleagues (2019) involving 35 studies (with one study site in the UK). The authors examined the effects of seclusion and restraint, finding the rates of Post-Traumatic Stress Disorder (PTSD) diagnoses following a coercive intervention ranged from 25% to 47%. This high rate of diagnosed PTSD is particularly alarming given the prevalence of past trauma amongst inpatient service users (Sweeney et al., 2016). An integrative review of physical and psychological harm resulting from restraint settings by Cusack and colleagues (2018) described eight themes relating to the impact of restraint, all of which were negative, and included dehumanising conditions, fear, and trauma or re-traumatisation. Thus, there is a real danger the use of restraint will be particularly damaging for service users with past trauma. This mirrors Akther and colleagues' (2019) systematic review findings that the use of coercion or being held down can remind service users of traumatic past events, such as sexual abuse. This is particularly concerning for service users with a diagnosis of BPD given that previous research that up to 84% of individuals with this diagnosis describe abuse before turning 18 years old (Zanarini et al., 1989) and that for women (the majority of whom attract the label of BPD) there is a distinct gendered experience of restraint relating to powerlessness and the denial of dignity (for example, staff not complying when requested to ensure service users' bodies were not exposed).

2.5.4 Service User Violence

For service users, literature on coercion relates to the dynamic between service users and staff; however, in an ethnographic, grounded theory study set on three wards in London, Quirk and colleagues (2005) found that service users are often fearful of the threat of physical harm or coercion presented by fellow service users. Service users were found to take active measures to maintain their own safety. The authors were careful to emphasise the risks to safety posed by fellow service users are likely symptomatic of limited resources and other broader, more contextual factors such as understaffing. Stenhouse (2013) attributed the

service users in her study being fearful of other service users at least in part to public discourse relating to 'mentally ill' individuals being "unpredictable, volatile and aggressive" (p. 3114).

Quantitative research suggests that staff experience violence from service users. In a questionnaire-based study of nurses and psychiatrists from across five West Midlands NHS Trusts, Nolan and colleagues (1999) found that nurses are significantly more likely to have been exposed to violence than psychiatrists ($p < 0.05$); 95% or more of perpetrators are service users and 50% of nurses indicated they sustained injuries. In a phenomenological interview-based study of eight qualified London-based inpatient mental health nurses, Currid (2009) found because staff regularly experience aggressive behaviour and violence from service users, this may impact on their willingness to therapeutically engage for fear of further victimisation.

Sheldon (2011) introduced an important critique of conventional staff views towards service user violence, specifying that while, to staff, the inpatient environment is their place of work, to service users, a ward is their home. Often, says Sheldon, service users are detained against their will within a bleak environment, where boredom and depersonalisation abound, and where they are at their most vulnerable. While violence does not have a place in mental health settings, neither does a decontextualised view of disempowered individuals.

2.5.5 Involuntary Care

In the UK and elsewhere, service users can be 'voluntary' or 'involuntary', referring to their legal status within an acute setting. In the UK, while voluntary inpatients are not subject to coercion given their legal status and protection, involuntary inpatients can be and are restrained when presenting a danger to themselves or others amongst other rationale (Mental Capacity Act 2005; The Mental Health Units (Use of Force) Act 2018). A recent systematic review by Akther and colleagues (2019), which included 56 papers (30 UK-based), indicated that involuntary care is frequently distressing, and coercion has an especially strong negative impact emotionally.

Using mixed-methods and a sample of 270 service users based in East London, Katsakou and colleagues (2011) found that even voluntary service users can feel coerced within the inpatient setting, mirroring Goodwin and colleagues' (1999) interviews with 110 service users from seven inpatient wards in rural England, who felt power and control feature heavily in the inpatient experience regardless of their admission 'status.' Katsakou and

colleagues (2011) found that 34% of patients felt coerced at time of admission. Females were more likely to feel coerced while half of those who felt coerced into admission continued to feel this way a month into treatment. The authors found that factors relating to feeling coerced included the perception that alternative treatments were preferred or more appropriate; not participating in admission; and not feeling respected and cared for. Service users who felt coerced into treatment overall felt more negatively about their admission and treatment.

Gilburt and colleagues (2008) conducted a PAR study involving interviews with service users who had experienced psychiatric inpatient services in London. The findings indicated coercive experiences were reported by all the service users interviewed. The experience of involuntary detention was attributed to coercive events that service users experienced because of their detention, not the legal process. This included the restriction of freedom as well as compulsory treatment. Like Katsakou and colleagues (2011), perceived coercion was reported by both voluntary and non-voluntary service users and involved threats of 'non-physical force' or other punishments following disobedience of staff.

In their meta-synthesis examining the experience of acute wards for service users with a diagnosis of BPD, Stapleton and Wright (2019) cite Fallon (2003) as well as Rogers and Dunne (2011), finding that service users with a diagnosis of personality disorder expressed strongly negative feelings regarding sectioning. Rogers and Dunne (2011) found participants felt that 'voluntary' admission is simply "another coercive way to detain people in hospital" (p. 230). Some participants felt coerced to remain on the ward to avoid sectioning. In contrast, Stapleton and Wright (2019) found some service users were 'addicted' to admission on the ward, where they felt cared for.

2.5.6 Overburden of Staff as Barrier to Positive Practice

For staff, other barriers to positive care included burnout. O'Connor and colleagues (2018) conducted a quantitative systematic review and meta-analysis involving 62 articles (20 UK-based). The authors found that factors related to burnout included higher workload and lower job control (where higher control meant less emotional exhaustion and increased professional accomplishment). The authors found emotional exhaustion to be higher in acute ward teams compared to other service types ($p < 0.0005$). Sorgaard and colleagues (2007), who surveyed over 200 each of ward and community staff at six psychiatric centres in five countries, one centre being based in the UK, also found that ward staff also demonstrated

higher rates of emotional exhaustion than their community-based counterparts and that working in acute wards implied a lack of control but superior contact with colleagues compared to community-based staff, although ward staff reported a worse social environment.

Cleary (2004) observed, held focus groups with, and interviewed Australian inpatient mental health nurses at a 22-bed ward, seeking to understand the 'reality of nursing.' Overwork was one of the four overarching themes found. While nurses acknowledged their overwork and felt administrative duties and paperwork redirected their attention away from service users, which they felt needed to change, their overall attitude towards their work was positive. Nurses seemed to take a certain level of pride in being "the 'backbone' of care delivery" (Cleary, 2004, p. 55). Although some staff may derive some benefit from viewing their roles this way, Currid (2009) describes a potentially burdensome consequence of this investment as staff may be unable to 'switch off' from work when at home, consequently limiting their ability to recuperate in their downtime, and further straining their emotional capacity.

2.5.7 Overburden on Limited Resources as Barrier to Positive Practice

One theme that recurs not only in UK literature but internationally is the challenge of inpatient bed management. In a study across 11 sites in England, spanning urban and rural settings, Higgins and colleagues (1999) collected qualitative and quantitative data (questionnaires, interviews and observation) from staff and service users relating to the experience of acute care. The authors found nine sites reported bed occupancies above 85%, five with at least 100% occupancy. One had 153% occupancy. The population of service users on wards were found to be diverse and a high proportion of inner-city populations were seen as difficult to manage due to the severity of their 'illness,' which was indexed by diagnosis (schizophrenia, 51%), highly dependent (12%) involuntary (47%) or under close observation (30%). Nurses' explanations for these figures included lack of suitable alternative accommodation; closure of long-stay psychiatric hospitals; increased psychiatric difficulties in urban centres; inefficient bed management; and ineffectiveness of the Care Programme Approach (CPA). According to staff, a consequence of delivering intensive care to these service users was limited time or capacity to implement structured programmes of care. The pressure to discharge service users was seen to lead to a 'revolving door syndrome' in which service users were discharged before meaningful care could be implemented,

deteriorating in the community, and being readmitted. Those settings that had retained higher numbers of beds and staff tended to facilitate increased nursing involvement in more care activities.

2.5.8 Limited Therapeutic Engagement as Barrier to Positive Practice

Staff and resource overburden have been suggested to lead to limited therapeutic engagement between staff and service users and this has been acknowledged by both staff and service users in the literature (Bee et al., 2006). Dixon and colleagues' (1995) definition of engagement, cited in Smith and colleagues' (2010), is "developing a trusting relationship between the treatment team and the individual" (p. 343).

Higgins and colleagues (1999) indicate that 'volume of administrative duties' is one of the four key themes that nurses feel impede their role. Rose and colleagues (2015) found that staff acknowledged their 'less than perfect' ability to spend time with service uses but felt 'powerless' to change this. Bowers and colleagues (2005) conducted an interview survey with 13 multidisciplinary staff, including ward managers, nurses, occupational therapists and consultant psychiatrists in the UK. They found that the demands of management and administrative tasks necessarily mean more time spent placing telephone calls and writing reports. Information management processes and care improvement policies including the Care Programme approach (Simpson et al., 2003), Care Management (Parry-Jones et al., 1998) and information management systems (Department of Health, 1999) also mean relatively less time for therapeutic activities. Despite this apparent diversion of staff time away from therapeutic interventions, still service users reported that care planning was rarely experienced as indicated by Rose and colleagues (2015) in their South London-based focus groups involving, amongst others, 37 service users with experience of inpatient services. Higgins and colleagues (1999) found that service users felt they experienced only a passing relationship with staff. In their systematic review, Akther and colleagues' (2019) findings echo this, indicating that service users expect to form interpersonal relationships with nurses but that non-clinical responsibilities serve as barriers.

To provide a critical counterpoint, however, in their review of life on acute wards, Lelliott and Quirk (2004) argue that nurses spend a large amount of time on the telephone or completing paperwork on behalf of service users (for example, assisting service users to obtain social security benefits), activities which tend to be valued by service users. Lelliott and Quirk (2004) argue these skills and commitments may be 'taken for granted' by staff

members, which may, in turn, contribute to the apparent guilt described earlier surrounding the reduced therapeutic time described earlier. In their review and synthesis of 23 international qualitative studies (three from England, one Ireland and one Northern Ireland) of nurse and service user interactions from the perspective of both service users and staff, Cleary and colleagues (2012) found reports of positive experiences of communication and staff personal characteristics from the perspective of service users and claim their research "critically challenges the dominant discourse that nurses within this setting do not interact therapeutically with their patients" (p. 77).

Therapeutic engagement of service users with a diagnosis of BPD may pose unique challenges. Stapleton and Wright (2019) conducted a meta-synthesis of qualitative data from 11 studies from three countries (four UK) examining the experience of acute psychiatric wards for service users with a diagnosis of BPD. In addition to finding negative experiences more prevalent in UK studies for service users with a diagnosis of BPD or 'non-caring care', staff knowledge and attitudes was one of the four overarching themes resulting in negative experience of care. Many participants reported staff demonstrating unfavourable attitudes towards them because of their diagnosis, and this phenomenon is supported by Rogers and Dunne (2011), who conclude "the biggest issue is surrounding staff attitudes and understanding of individuals with a personality disorder" (p. 232).

The reports of staff being unavailable to service users with a diagnosis of BPD may at least partially be explained by O'Connor and Glover's (2017) meta-synthesis of nine articles (three UK, one Ireland) relating to hospital staff experiences of their relationships with service users who self-harm. The authors found that a cycle of staff emotional reactions to service user behaviours are likely to impact greatly on the therapeutic relationship. This was said to begin with staff feeling discouraged by service users continuing to self-harm despite their interventions, leading to a depletion of empathy, further leading to avoidance of service users as a coping mechanism or humiliation of service users if avoidance is not sufficient.

2.5.9 Summary of 'What are the Barriers to Positive Practices?'

The use of coercion is an assumed feature of inpatient care. While staff view the use of restraint as a reaction to service users' internal factors, service users view the behaviour that leads to the use of restraint as a natural consequence of their extreme context. The experience of coercion is almost always experienced negatively (sometimes as re-traumatising) and stems from service users' experiences of dehumanisation and a lack of

'normal interaction.' A small number of positive experiences of coercion have been noted which may relate to contextual factors such as staff-service user relationships. Service users may perceive one another as threats to their own safety and take measures to protect themselves and staff appear to experience high rates of violence which may impact on their willingness to engage with service users.

Voluntary and involuntary service users can feel coerced in admission and throughout treatment. Some service users with a diagnosis of BPD experience anger at being involuntarily detained while others are 'addicted' to feeling cared for in the ward setting. Inpatient staff are particularly prone to burnout. Service users with a diagnosis of BPD face the unique barrier of staff holding negative attitudes and beliefs towards them based on their diagnosis; this has been said to impact on staff willingness to engage with these service users and may impact on the therapeutic relationship.

Given the limited reported time staff spend therapeutically with service users, ways of maximising existing time together should be explored, such as using psychological formulation.

2.6 How BPD Care Aligns and Differs

The above review highlights several areas of overlap between factors that promote positive experiences of services for service users with a diagnosis of BPD. Mirroring the value placed on relationships between staff and service users, Acford and Davies (2019), Morris and colleagues (2014) and Stapleton and Wright (2019) found that service users with a diagnosis of BPD emphasise positive relationships where they can talk and be listened to. Like factors that lead to negative experiences of care for the broader population of service users, service users with a diagnosis of BPD also report negative experiences with involuntary admission and that even voluntary admission can feel coercive (Rogers & Dunne, 2011). Bowen (2013) looked specifically at experiences of good practice by staff working with service users with a diagnosis of BPD and developed four key themes, including SDM, open communication, peer support, and social roles.

Recovery is one area that has been suggested to be somewhat different for service users with a diagnosis of BPD. In a systematic review and meta-analysis of factors that promote personal recovery for service users with a diagnosis of personality disorder, Shepherd and colleagues (2016) found higher order themes of safety and containment as well as social networks and autonomy. A great deal of overlap was found relating to relational

factors: for example, relating to safety and containment, the authors found this can relate to relationships, social networks or environments. Thus, while safety is essential for service users with a diagnosis of BPD, this seems largely mediated through secure relationships with others. In a PAR-based investigation, Castillo and colleagues' (2013) study mapped the process of personal recovery with 60 service users with a diagnosis of BPD in the UK. They conceptualised their findings in a similar way to Maslow's (1943) pyramid of the Hierarchy of Needs, the base levels including a sense of safety and trust as well as feeling cared for. This is seen to support positive relationships, including with oneself, which the authors contend create the foundation upon which 'higher order' processes (recovery) can occur. An Australian study by Donald and colleagues (2017) indicates that for service users with a diagnosis of BPD, recovery entails a journey primarily of self-acceptance which is "enabled through a complex set of processes revolving around the self, which are supported and reinforced though dialogue or relationships with other(s)" (p. 358).

However, Katsakou and colleagues (2012) found that services are largely unable to support relational difficulties, instead focusing on traditional risk-related factors such as self-harm. Service users in this study indicated a desire to explore their experiences of previous trauma, which the service was less equipped to support. This suggestion of services being unable to meet service user needs relating to relational support may at least partially explain Zanarini and colleagues' (2012) findings that while remission of symptoms is common amongst those with a diagnosis of BPD, longer term psychosocial functioning occurs less frequently.

Besides the perceived misalignment between service priorities and service users' preferences for care, another barrier to positive practice for service users with a diagnosis of BPD are staff attitudes. As discussed in Chapter 1, staff views towards service users with a diagnosis of BPD can sometimes be affected by the stigma around this diagnosis and result in therapeutic nihilism (Campbell et al., 2020), which can interfere with staff willingness to engage with service users. Bowen (2013) refers to working alongside service users with a diagnosis of BPD as an "intense therapeutic challenge" (p. 497). Staff knowledge and understanding of BPD is seen to be key for supporting positive experiences (Stapleton & Wright, 2019).

The important differences identified here appear to be that service users with a diagnosis of BPD desire staff support to develop safety and a positive sense of identity through the therapeutic relationship as well as to explore previous trauma. These processes may be supported via the process of psychological formulation, as indicated by Yeandle and

colleagues (2015). Psychological formulation can also increase staff understanding and empathy towards service users, which may assist to counterbalance the therapeutic nihilism described by Stapleton and Wright (2019).

2.7 Gaps in the Literature

Barring a few notable exceptions (Bowers et al., 2005; Kelly et al., 2016; Totman et al., 2011), few studies investigate MDT perspectives, with many studies focusing exclusively on the perspectives of nurses or HCAs (Acford & Davies, 2019; Cutcliffe & Happel, 2009; Gabrielsson et al., 2016; Rose et al., 2015). Although nursing staff make up a large proportion of inpatient staff and undeniably spend much time with service users, it is nevertheless important to capture the perspectives of other staff who work therapeutically with service users and form part of the team and community.

In their study of the everyday experience of inpatient settings from the perspective of service users and staff (nurses and HCAs), Rose and colleagues (2015) emphasised the relative scarcity of research on this topic and Junghan and colleagues (2007) emphasise the importance of assessing staff and service user perspectives separately.

Gaps have been identified relating to the examination of recovery, SDM (Beyene et al., 2018; Thompson & McCabe, 2012) and PRT (Just et al., 2021; Reddington, 2017) and their practical application in the acute inpatient setting. For example, Beyene and colleagues (2018) identified the need for interventions to examine the conditions in clinical practice required for SDM to take place (Gravel et al., 2006; Perestelo-Perez et al., 2011).

The relationship of these practices to each other also has been identified as in need of exploration; for example, Reddington (2017) identified a gap in the research on how PRT impacts service users and whether it promotes recovery. Additionally, research calling into question the feasibility and/or desirability of recovery practices including SDM and PRT in acute settings should be urgently considered (Waldemar et al., 2016).

De Ruyssher and colleagues (2019) argue for the use of qualitative research that is ‘context-close’ and grounded in the perspectives of those directly involved to explore recovery processes given their inherent idiosyncrasy and versatility of services.

As discussed, there is a paucity of research that focuses on positive practice, particularly within the context of services for service users with a diagnosis of BPD. That which exists (Acford & Davies, 2019; Pereira & Woollaston, 2007) either does not explore service user perspectives, does not provide broad-based examples of specific practices, or has

not examined the perspectives of staff who have undergone specialist training and the environment or practices that result from this. For instance, the research described above has indicated attitudes towards service users with a diagnosis of BPD are worse in the UK (Stapleton & Wright, 2019) and that the therapeutic relationship is experienced differently in the UK (O'Connor & Glover, 2017) compared to other countries. These findings suggest that further research should be conducted to explore the subjective experiences of staff and service users in UK acute inpatient and specialist settings.

The following gaps relate to those of the literature on psychological formulation and are followed on in Chapter 7. Existing research reveals that some service users are not best served by psychiatric diagnosis and may appreciate the offer of alternative means of understanding their difficulties within inpatient services. Trust and respect, which are deemed essential for the development of the therapeutic relationship and ultimately positive experiences of treatment, may be enhanced using psychological formulation (Acford & Davies, 2019). Psychological formulation practices may support both staff and service users to make the most of their limited one-to-one time by ensuring the therapeutic value of their encounters; the development and acceptability testing of a model of formulation is the first step in investigating this. A psychological formulation model that provides specific suggestions relating to how to ensure meaningful collaboration with service users may improve service user experiences of involvement; this research provides such a guide.

3. Chapter 3 Methodology Chapter

3.1 Chapter Overview

This chapter addresses the methodological approach taken throughout this research, including both methodology and methods. This research accepts Mackenzie and Knipe's (2006) distinction between methodology and methods as follows: methodology is the "overall approach to research linked to the paradigm or theoretical framework" (Methodology and Paradigms section, para. 2) while methods refer to "systematic modes, procedures or tools used for collection and analysis of data" (Methodology and Paradigms section, para. 2). This chapter attempts to focus on the methodological approach taken overall as well as provide a justification for the methods chosen. Much of the detail related to the methods can be found in each empirical chapter (Chapters 5, 6, 8, and 9). The theoretical framework, which forms part of the methodology, is covered in depth in Chapter 4.

This chapter begins with a description of the study design, including the identified aims and research questions. A justification of the methodology follows, including the use of a Mixed Methods-Case Study design (MM-CS; Guetterman & Fetters, 2018). A link between the overarching mixed methods approach and the theoretical framework is made. Methodological justifications for the methodology chosen for this research follow, along with a description of the participants and the approach to analysis. The chapter concludes with a review of the ethical challenges presented by this research and how they were addressed.

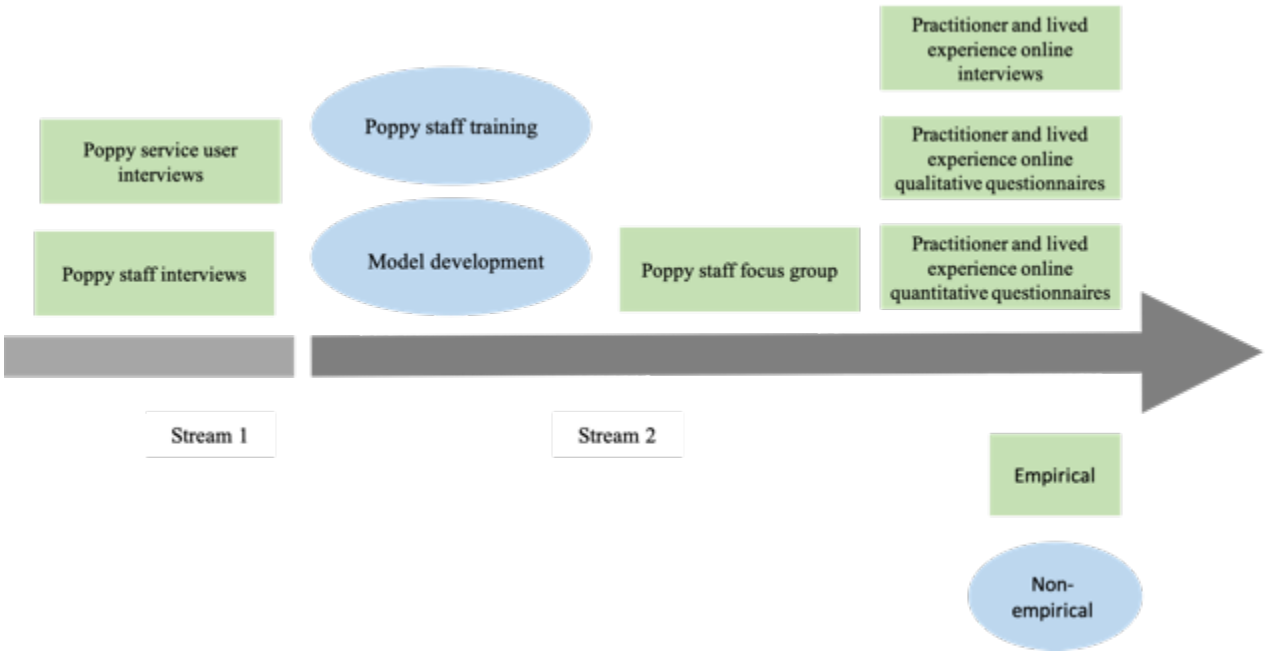
3.2 Study Design

This research was comprised of two streams (see Figure 3.1):

Stream 1 involved a case study examining the perspectives of staff and service users on Poppy ward, a specialist inpatient ward that has undergone extensive service improvement and the identification of how to support and extend their good practice (see Chapter 1). Stream 2 entailed both a description of the process of (1) devising a collaboratively developed psychological formulation model, the PNM; as well as 2) a mixed-methods exploration of its acceptability, involving a focus group with Poppy ward staff following staff training on the PNM; as well as an online survey and interviews with a broader sample of mental health practitioners and participants with lived experience. A collaborative approach involving PPI was adopted for this research; see Chapter 4 for a detailed description.

Figure 3.1

Sequence of Events



The aims of this research were:

1) To explore staff and service user experiences of care on a positive practice ward; 2) to describe the development of a collaboratively developed model of psychological formulation, the PNM; 3) to explore the acceptability of the PNM in a specialist inpatient context; and 4) to explore the wider acceptability of the PNM and solicit suggestions for its implementation, including any suggested improvements.

A fifth aim, identified at the outset of the research, was to explore current staff formulation practices on the positive practice ward and evaluate outcomes based on the staff training intervention; however, the data collected was insufficient to adequately address this aim and was therefore removed (see Appendix B for the data).

To address these four aims, the research entailed two streams of research that addressed the following research questions.

3.2.1 Stream 1

In line with the critical realist case study approach (Easton, 2010), this research sought to explore:

1. What factors do MDT staff believe are involved in the operation of Poppy ward as a positive-practice specialist ward for service users with a diagnosis of personality disorder?

2. What factors do service users believe are involved in the operation of Poppy ward as a positive-practice specialist ward for service users with a diagnosis of personality disorder?

3.2.2 Stream 2

This stream sought to describe the development of the PNM, its acceptability within an applied specialist ward, and explore wider perspectives toward the Model to further develop and validate its acceptability and relevance. This stream asked:

3. What does a model of psychological formulation, collaboratively developed alongside local stakeholders to address their needs, look like?
4. What are specialist inpatient staff views of the PNM and its acceptability? What are the enablers and barriers?
5. What are wider stakeholder (clinicians and/or individuals with lived experience of mental health difficulties) views of the PNM and its acceptability? What are the enablers and barriers?

All five questions lent themselves to qualitative methods of inquiry with focus on the context, experiences, and the meanings individuals take from their lives. Qualitative research conveys these individual experiences and meanings by quoting participants and acknowledging the irreducible complexity of particular forms of knowledge such as setting and context to figures and statistics (Creswell et al., 2011). Denzin and Lincoln (2005) describe qualitative researchers as seeking to investigate the individual's perspective via detailed and in-depth inquiry and wish to 'examine the constraints of everyday life' by confronting it. Qualitative research seeks to achieve a richness with data to situate an account within its historical and time-constrained context. Similar to the motivations described by Berry and colleagues (2016) in a mixed-methods exploration of formulation in a long-term rehabilitation setting, here, the aim of the qualitative element of the research was to identify key 'active ingredients' or variations in effectiveness as identified by participants.

Research question five lent itself to both qualitative and quantitative methods of inquiry. The reason for the adoption of quantitative approach in addition to qualitative was twofold: the first was that, because of COVID-19, these research questions needed to be addressed via remote data collection. To limit the burden of the research necessitated the inclusion of quantitative, ostensibly faster to complete, survey questions. The second rationale was theoretical. As Maxwell (2011) argues, both qualitative and quantitative research have the

potential to limit diversity in their search of general accounts in different ways (Maxwell, 1995). This, in addition to the critical realist framework (described in Chapter 4) which guided this thesis, leads to the conclusion that the results of any one method are inherently influenced by existing underlying causal mechanisms (McEvoy & Richards, 2006) and justifies the employment of multiple methods to broaden access to other explanatory theories.

3.3 Justification of Methodology

3.3.1 Mixed Methods

To address the research questions and taking into consideration the need for both qualitative and quantitative data collection methods, this research incorporated both. Research that intentionally integrates both quantitative and qualitative data collection within a programme of study is referred to as 'mixed' methodology, or 'mixed methods' research (Creswell et al., 2011). To briefly address terminology here, I acknowledge the imperfect delineation of the concepts of 'qualitative' and 'quantitative' research, which, as has been pointed out by others (Wood & Welch, 2010), are crude and often misguidedly dichotomise types of research in potentially problematic and limiting ways. For the sake of ease and clarity, I adopt these terms; however, interested readers are directed to authors such as Wood and Welch (2010) for a more in-depth discussion.

The position taken in this research was that the use of both methods fortified the strengths of both while bolstering their respective weaknesses. Qualitative methodologies allow for participants to communicate their experiences more fully and richly and provide space for context. Quantitative measures, on the other hand, provide a more succinct picture of participant views, and the use of validated measures allows for comparability to other research as well as a fuller picture of participants' features using demographic information. By combining both qualitative and quantitative methods, it is possible to develop a fallible and negotiable model of the 'real world' and its influence on humans in this particular context (Johnstone et al., 2018).

3.3.2 Case Study

Similar to the rationale described by Walton and colleagues (2020), case studies allow for an in-depth (Sandelowski, 2010) exploration of unique cases (Yin, 2009). Further, Dattilio, and colleagues (2010) argue for the relevance of case studies within a larger mixed-methods design, as narratives allow for a range of perspectives of the same treatment. The other

scientific benefit described is that the communication of case study findings can inform practice in a more direct manner than other research publication types.

Here, a qualitative single case study was employed in Stream 1 to investigate the experiences of staff and service users on Poppy ward.

3.3.3 Mixed Methods-Case Study

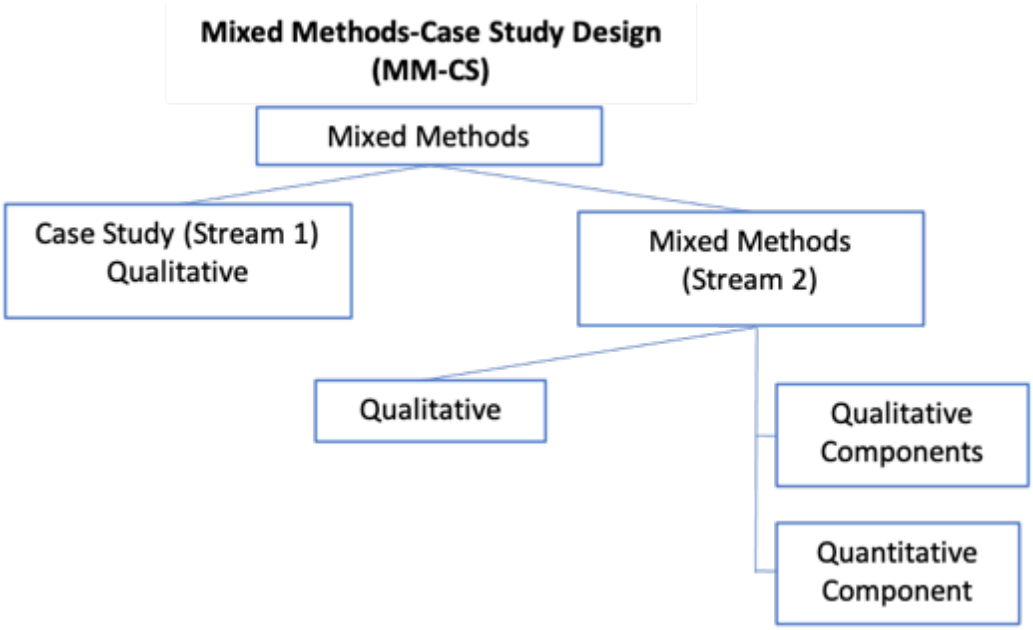
The methodology which was thought to most appropriately and thoroughly address the research questions identified as well as the considerations above was mixed methods combined with a case study. Although not a traditional approach, it is nonetheless represented in the literature: Guetterman and Fetters' (2018), systematic review identified two innovative approaches to integrated mixed methods and case study designs: the Case Study-Mixed Methods Design (CS-MM) and the Mixed Methods-Case Study Design (MM-CS; see Figure 3.2).

The difference between the two is that while the CS-MM comprises of an overarching case study which employs mixed-methods, the MM-CS mixed methods approach encompasses both a case study (which can include qualitative and quantitative data) and a qualitative component.

The present research combines and extends these approaches with an overarching mixed methods approach, similar to MM-CS and thus took on this label. In this research programme, the Mixed Methods umbrella branched into a qualitative case study arm and a mixed-methods arm.

Figure 3.2

Mixed Methods-Case Study Design



The three dimensions necessary to situate the type of mixed methods employed include level of mixing; time orientation; and emphasis of approaches. This research entailed a partially mixed design, meaning the data was mixed at the interpretation phase. Time orientation varied in this research programme: Stream 1 entailed the case study with data collection occurring at the same time. Stream 2 involved an exploratory sequential design with an embedded concurrent phase, in which qualitative data (the focus group) was collected first, followed by both qualitative and quantitative data (the acceptability survey) which were collected simultaneously, followed sequentially by a qualitative phase (interviews). The emphases are demonstrated below in the conventional mixed-methods notation style first developed by Morse (1991) and added to by Tashakkori and Teddlie (1998) as well as Plano Clark (2005); see Creswell (2014, p. 12) for an elaborated explanation.
(Stream 1 / case study: QUAL) → (Stream 2: QUAL + quant → QUAL).

The qualitative phases were given emphasis in this research due to the explorative nature of the research; its small scale; and the desire to contextualise the data as richly and deeply as possible to convey the meaning expressed by participants in their responses.

3.3.4 Briefly Addressing the Incompatibility Thesis

It is beyond the scope of this work to describe in full the history of debates which have permeated discussions in the literature about mixed methods research; however, it merits recognition that still today there are researchers and schools of thought which oppose the mixing of qualitative and quantitative research methods. Though the debate has occurred

at different levels of inquiry including the political and the technical, most debate occurs at the philosophical level.

The philosophical incompatibility thesis refers to the belief that certain research methods have inherent epistemological assumptions which may be oppositional if combined. Some view qualitative and quantitative methods as oppositional and are therefore seen to result in a philosophically incoherent methodology when mixed. Hathcoat and Meixner (2017) propose a more nuanced view of this proposition, suggesting traditionally labelled 'quantitative' and 'qualitative' methods vary in their epistemological assumptions which range from positivist to interpretivist, and where philosophical assumptions as opposed to the type of data (text versus figure-based) is relevant.

The critical realist perspective adopted here leads to an emphasis on ontology which aligns with the conditional incompatibility thesis, and which McEvoy and Richards (2006) deem an 'anti-conflationist' position. This entails the view that it is appropriate to combine methods when a common ontological and epistemological position can be sustained. I argue the methods selected for the purpose of this research are philosophically coherent. The identification of the theoretical perspective adopted for this research follows and is included in a description of the relevant epistemological and ontological assumptions in Chapter 4.

For the purpose of aligning the mixed methods approach with critical realism here, the quantitative element of this study, the inclusion of which may draw the most critique, aligns with the critical realist stance on the purpose of quantitative methods of inquiry. Critical realism prescribes the use of quantitative data to simplify descriptions of the subject of study by demonstrating their properties statistically. This was done not for prediction purposes or to imply a causal relationship, but to describe the object of study; this position aligns with the critical realist perspective described in detail in Chapter 4.

In this research, the decision was made to include qualitative data alongside quantitative data given the critical realist framework views the combination of as many means of eliciting views as possible to encourage a broader, more nuanced perspective. The exploration of conflicting views promotes the possibility of generating ways of understanding or theories that can be tested (Danermark et al., 2019).

3.4 Justification of Methods

3.4.1 Stream 1

Stream 1 involved a case study of service users and staff of a positive practice ward (see Chapter 1). The method chosen for this was interviews, semi-structured interviews specifically. The rationale for this decision follows.

3.4.1.1 Semi-Structured Interviewing. Interviews were identified as the most appropriate method of investigating meaning construction by participants, to illuminate the participants' interpretation of their reality, as well as gain access to the social context, resources, and limiting factors participants encounter (Smith & Elger, 2012). Semi-structured interviews were chosen for this stream to allow for flexibility in pursuing lines of enquiry as the interview unfolded. The interview schedule served as a guide and was not intended to be adhered to rigidly (see Chapter 4 regarding the SUAG's role in the development of the interview schedules). Both Poppy staff and service users participated in semi-structured interviews.

3.4.2 Stream 2

Stream 2 involved a mixed-methods approach including 1) the PNM's development; 2) following staff training on the PNM, an evaluation of its acceptability through a focus group with Poppy ward, and 3) an online phase of online qualitative and quantitative questionnaires followed by online interviews.

See Chapter 7 for a full account of the PNM's development and a description of the staff training on the PNM delivered to Poppy ward.

3.4.2.1 Focus Group. The key objectives following the staff training were to have participants share and compare their experiences of the training, explore their shared views regarding the Model's acceptability as well as enablers and barriers, and develop and generate ideas of how to address barriers and/or modify the implementation strategy for the benefit of future research. Given these targets, a focus group was decided to be the most appropriate method of evaluation (Breen, 2006). As summarised by Tickle and Braham (2012), focus groups can also enable the perception of a safe forum (Sim, 1998); cohesiveness, empowerment, and mobilisation (Morgan, 1996; Sim, 1998); as well as clarify and expand discussion of views (Kitzinger, 1995). These were all desirable outcomes for the use of a focus group in this research (see Chapter 8 for the results).

3.4.2.2 Online Quantitative Questionnaires. Through the collection of quantitative questionnaires, data was collected to simplify descriptions of the PNM's acceptability by demonstrating its properties statistically. This was done not for prediction purposes or to imply a causal relationship, but to describe. This position aligns with the critical realist perspective described in detail in Chapter 4; see Chapter 9 for quantitative questionnaire results.

3.4.2.3 Online Qualitative Questionnaires. Qualitative surveys have been suggested to elicit deep, nuanced responses from participants in the tradition of other, more common qualitative methods such as interviews. This challenges what Braun and colleagues (2020) call "misplaced" assumptions regarding the capabilities of qualitative surveys to capture the experiences of participants. The rationale for the collection of qualitative data was to create an opportunity for participants to provide as much context, information, and space to reflect as they wished. As acceptability was the focus of Stream 2 and this topic presents the possibility of a multitude of ideas being explored, it was key to allow for a less restrictive means of response.

3.4.2.4 Online Semi-Structured Interviews. Justification for the use of semi-structured interviews aligns with that described above in Section 3.4.1.1. However, in Stream 2, interviews were carried out online through a video conferencing platform due mainly to pragmatics. First, these data were collected during a period of physical distancing measures imposed by the UK government due to the COVID-19 pandemic, which necessitated remote data collection. Second, the aim of this phase was to gain a wider range of participants, geographically, culturally, and otherwise; the use of online interviews enabled this given its superior convenience. Recent research (Gray et al., 2020) indicates a host of positives to emerge from the use of web-based interviewing, including: 1) convenience; 2) potential for enhanced privacy; 3) accessibility and 4) its time-saving nature (for example, no need to travel). Although there are likely several disadvantages, these are not explored here.

Given the need to justify the inclusion of more than one qualitative method in one study as described by O'Reilly and colleagues (2020), here the use of interviews following the qualitative survey allowed for follow-ups to questions, the opportunity to probe responses to the previous survey phase and provided space to give examples, add nuance, and expand on responses.

3.5 Participants

Participants in both streams included those with both lived experience and practitioners (as well as those who identify as both). Specific recruitment procedures are described in Chapters 5, 6, 8, and 9 as well as participants' demographic characteristics. The present research is small-scale case and acceptability study and therefore considerations surrounding sample size are based on pragmatics surrounding the availability and feasibility of the research to Poppy ward and the resources available (Leon, Davis, & Kraemer, 2011).

3.6 Data Analysis

Qualitative data were analysed using reflexive thematic analysis (RTA; Braun & Clarke, 2006; 2020). This approach was chosen due to its alignment with critical realism given its interest in experience (Braun & Clarke, 2020) as well its established use with mixed methods (McBeath et al., 2019). The flexibility of thematic analysis has been acknowledged as both liberating and curtailing. While it allows for nuanced, rich data, it can equally lead to "poorly constructed and executed analysis" (Trainor & Bundon, 2020, p. 1). Braun and Clarke (2020) have decried common problems in research employing RTA and there is a

dearth of transparent accounts of its process (one notable exception was recently published; Trainor & Bundon, 2020). However, Braun and Clarke have published an abundance of guidelines and examples of approaches (Braun & Clarke, 2019a; Braun & Clarke, 2019b), which was helpful in undertaking this analytic approach.

Quantitative data was not collected in abundance given small participant numbers and because data was only collected at one point in time. Thus, descriptive statistics were used in the analysis of quantitative data, which aligns with the critical realist agenda for the use of quantitative data to provide 'reliable descriptions' (McEvoy & Richards, 2006).

Empirical chapters 5, 6, 8, and 9 each expand on the particular procedures taken and provide a description of the steps taken to ensure the rigour and quality of analysis.

3.7 Ethical Considerations

Aspects of this research (empirical chapters 5, 6, and 8) required NHS ethics, which was granted (18 NW 0212, IRAS ID 227356; see Appendix C) but which also was subject to various amendments throughout the research (see Appendices A and C). An application to the Anglia Ruskin University's School Research Ethics Panel (SPREP), ratified by the Faculty Research Ethics Panel (EHPGR-28), was granted for the online phase of Stream 2 (see Appendix C).

By conducting research with human participants, I was ethically obligated to adhere to the Belmont principles: respect for persons, beneficence/non-maleficence, and justice. The following section details how I went about this.

Written or digital consent was obtained from all participants. Although the SUAG (see Chapter 4) reviewed the interview schedules to ensure the questions asked throughout this project were of an everyday nature and not likely to provoke an emotional response, emotional evocation was an acknowledged possibility due to the nature of qualitative research (Hammersley & Traianou, 2012). This, combined with the possibility of collecting sensitive information, meant all participants were advised they could terminate or pause the interview at any time or skip any questions they did not wish to answer. Debriefing forms with local mental health helplines were also provided and discussed.

All participants were advised the data they provided was treated with care to preserve their privacy and anonymity; to this purpose, all participants were assigned pseudonyms. All data were stored on password-protected computers following relevant information security guidelines (either NHS or Anglia Ruskin University as it applied). All participants were

informed of what would need to happen in the event of a disclosure, including informing my supervisor and potentially others.

Especially important for data collection at Poppy ward, my role as outsider was described: all participants were informed that what they said would not affect their care, lives or change how I felt about them. Interviews took place in quiet, private spaces. All participants were given the option to withdraw their data; none did.

Consent was given to digitally record the focus group and interviews. See Chapters 5, 6, 8, and 9 for details related to ethics adhered to throughout this research.

4. Chapter 4 Theory and Philosophical Framework

4.1 Chapter Overview

The following chapter will begin with an orientation to the position this research took towards how best to understand mental health and provide care. This is followed by a description of the selection process for the theoretical orientation for this research and the ultimate identification of critical realism, which is then described in detail. The epistemological and ontological position of this research follows. The chapter concludes with a review of the relevance and importance of PPI in mental health research, followed by a description of how PPI was implemented in this research via a SUAG and their activities throughout the research process.

4.2 Theoretical Perspective

A variety of theoretical perspectives were considered for the purpose of this research. According to authors Creswell and Plano Clark (2017), theoretical perspectives (what they term 'worldviews') can be broadly defined as a particular way of viewing the world, along with the various philosophical assumptions associated with that point of view. Creswell and Plano Clark (2017) identify four worldviews: postpositivism, constructivism, transformative, and pragmatism. Teddlie and Tashakkori (2003) parse positivism and postpositivism into two worldviews, and so their taxonomy expands to that of five worldviews. Although these are often the paradigms cited in the literature, other mixed-methods paradigms have been suggested (for example, Harrits, 2011, with nested analysis, praxeological knowledge; Lincoln and Guba's 2003 paradigms for qualitative research, namely constructivism, critical theory, and participatory paradigms; Schwandt, 2003, with qualitative paradigms interpretivism, hermeneutics and social constructionism).

The philosophical framework was the subject of much consideration for this research given the research questions and the identification of mixed methods as the most appropriate data collection route. The underlying philosophy supporting mixed methods has been the subject of much discussion in the prevailing literature given concerns about the incompatibility thesis, which was discussed in the previous chapter.

4.3 Critical Realism

Critical realism (Bhaskar, 1998) was ultimately chosen to support this research given its theoretical coherence in providing support to both qualitative and quantitative research

methods and its ontological and epistemological assumptions. Much can be said about critical realism and many philosophical textbooks have been written on the subject. In the interest of brevity and relevance, here I discuss only the topics which maintain a direct link to this research and refer readers to works by Bhaskar, Cruickshank, Sayers, and Archer (Archer et al., 2013; Bhaskar, 1998; Cruickshank, 2003) for further discussion.

To first summarize the philosophical tenets of critical realism, I will provide an overview of the defining set of ideas critical realism represents to best orientate the reader to this particular understanding of the world. These include a realist ontology, epistemic relativism, and judgmental rationality (Archer et al., 2016).

According to Sayer (2010), the most basic tenet of realism is the independence of the world from our thoughts about it. This perspective entails an ontological realism; that is, events in the world occur and exist independently of our perception of them. The preoccupation of critical realism with ontology deviates from other prominent philosophical approaches which are largely concerned with epistemology. Further, unlike other philosophies, the critical realist approach assumes that reality can be parsed into three layers: the real, the actual, and the empirical (Danermark et al., 2019). The ‘real’ refers to objects and their associated structures, powers, and liabilities. The ‘actual’ are the mechanisms which are triggered by the real which produce change. The ‘empirical’ is what actors experience and is a product of the real and the actual (Fairclough et al., 2004).

Thus, critical realism distinguishes itself from prevailing worldviews including postmodernism and constructionism by resisting the acceptance of the idea of there being no rational self and that knowledge is simply a reflection of commonly accepted discourse (Cruickshank, 2003). Critical realism rejects this notion, arguing that it is possible for the self to be socially mediated but not determined (Cruickshank, 2003); and the self can obtain knowledge of reality distinct from our representations of it via fallible theories.

4.4 Epistemology and Ontology

Ontological realism aligns with my own developing worldview, which evolved throughout the process of the research. Starting out from the perspective of an unexamined post-positivism, speaking to those with lived experiences, attending conferences, being exposed to activist blogs and emerging discourse critiquing the medical model and the dominant ‘DSM mindset’ (Johnstone et al., 2018) forced me to challenge my own worldview for the first time. In terms of how ontological realism buttresses this research, its exploratory

status allows for the tentativeness required of any conclusions as well as the acceptance of the interpretation of results as fallible.

Epistemic relativism refers to an epistemology, or theory of knowledge, that views knowledge of reality as situated in a historical, social, and cultural context (Archer et al., 2016). Epistemic relativism accepts knowledge as being dependent on context, concept, and activity, accepting agents' accounts as fallible (Archer et al., 2016). Further, while realism entails a pursuit of the truth, this 'truth' is situated within a particular time in history and cannot be seen as removed or objective in any way. As Archer and colleagues (2016) state, however, this does not lead to the conclusion that knowledge is an impossible goal, only that our views of the world are perpetually fallible and historically situated and necessitate such concepts as methodological pluralism to access reality by different means.

The mixed-methods design of this research thus aligns well with epistemic relativism; the use of quantitative questionnaires in addition to qualitative questionnaires, semi-structured interviews, and a focus group allowed for the exploration of Poppy ward and the acceptability of the PNM at a greater depth than any one method used alone. Additionally, the setting of the research as well as the attempt to understand underlying attitudes and perceptions of the actors supported the choice of critical realism. Critical realism accommodates complexity with its multiple levels of reality and acknowledgement of unseen mechanisms with forces and potentialities of their own; this approach aligns with the exploration of multiple sources and mechanisms of power explored via the PNM.

Arguing for the logic of the third argument in the set of philosophical positions espoused by critical realism, Archer and colleagues conclude with judgmental rationality as the natural product of ontological realism and epistemic relativism: critical realists must therefore believe there are criteria for judging the explanatory power of theories about the world, or as phrased by Danermark and colleagues (2019), judgmental rationality refers to the proposed "theoretical and methodological tools which can be used to discriminate among theories regarding their ability to inform us about the external reality" (p. 10). Pilgrim (2019) indicates the basis for judging this proposed knowledge as an 'enlightened' version (Pilgrim, 2019) of 'common sense' in identifying the 'best fit' explanation for a phenomenon. Archer and colleagues (2016) argue that it is possible for social science to improve its knowledge about reality over time, and to make relatively justified statements about the 'real world' while at the same time being historical, contextual, and subject to change.

As stated above, the second part of this exploration of critical realism is grounded in methodology, theory, and the proposed contribution of critical realist-informed social

sciences to society. Danermark and colleagues (2019) propose a framework of critical realist methodology that can be summarized by fundamental arguments, one of which informed this research: the overarching endeavor in social science research is to provide an explanation for events and processes, which involves first isolating and describing properties and causal mechanisms responsible for events; and then providing a description of what circumstances generate certain mechanisms and how. One of the aims of this research was to explore the acceptability of the PNM empirically; this was measured quantitatively through measures of acceptability. The data generated via questionnaires was further contextualized using the testimonies of participants through the interviews.

The lens of critical realism provided additional rationale for the inclusion of the SUAG in this research. Realist approaches allow for the necessary consideration of dynamism and context (rather than controlling for them), which supports the development of an understanding of which interventions will work in applied settings (Marchal et al., 2012). By acknowledging this context, the reasoning and actions of the individuals involved in the research may explain the prospective integration or implementation of the PNM (Wand et al., 2010). The SUAG with its insight regarding culture and practices helped inform the analysis of interview-based data, and its advice was instrumental regarding which gatekeepers to approach, how to enhance recruitment, and how to increase the acceptability of the PNM itself.

4.5 Patient and Public Involvement

This research sought to forward the movement towards collaborating meaningfully with service users within mental health research. Representation of service user perspectives was enabled in this project by including PPI. PPI refers to the inclusion of service users, carers, and members of the public in research which ultimately affects them. Evidence of patient and public involvement is increasingly becoming a requirement for funding by research funding bodies given the ethical and practical benefit of conducting research based on the feedback and contributions of stakeholders. The NHS national advisory group, INVOLVE, has been established to guide PPI in health and social care research and makes important distinctions between involvement, participation, and engagement in research. Examples include carers or service users being joint grant-holders, members of a project advisory group, or commenting on and developing participant-facing materials (INVOLVE, 2012).

There is some debate surrounding PPI, mainly held by professionals, concerning whether and how it should be evaluated (see discussions by Crocker et al., 2017; Edelman and Barron, 2016; and Staley, 2015). The stance I take here is that PPI offers both constructivist (PPI is a morally correct undertaking in research given its benefit to the quality and relevance of research) and deontological (PPI returns the power and right to make decisions to stakeholders) benefits. It also serves an important theoretical purpose (Telford et al., 2002) in that it facilitates a more holistic picture of health, which traditionally concentrates on disease, or clinical problems versus the individual's experience of their own difficulties. These perspectives allow deeper insight into phenomena.

Esmail and colleagues (2015) summarise the empirical research indicating the value of PPI in research, including its enhancement of the methodological rigour of the research by improving its quality and validity (Ahmed & Palermo, 2010; Barber et al., 2011; Allen-Meares et al., 2005); development of research ideas and feedback on usefulness of research (Lindenmeyer et al., 2007); shaping research questions (Abma et al., 2009); increasing recruitment (Lindenmeyer et al., 2007); and increasing learning (Barber et al., 2011).

The inclusion of PPI has also supported deontological aims, as demonstrated through research; service users have assisted to ensure data analysis reflects patient perspectives and service user involvement has affected the provision of services across a range of settings (Crawford et al., 2002). The involvement of service users has been shown to influence directorate research agendas (Gordon et al., 2018) and service users further indicated their participation in research has contributed meaningfully to their professional or academic community 'give back' to the NHS (Gordon et al. 2018). The following section will describe how PPI was utilised within this research.

4.5.1 Service User Advisory Group

A SUAG was recruited to ensure the service user perspective was considered throughout the project. The SUAG's function was to provide feedback, help with specific tasks, and raise issues of concern (Davies, 2016). Without lived experience of mental health services or professional experience within the context of acute services myself, with the assistance of my local Research and Development User and Carer Manager, I recruited a core membership of three individuals with lived experience during the Model development phase. Two of the original three continued to contribute during the analysis phase. These two core members attended approximately 20 meetings in total. An additional two one-off meetings

were held with individuals who were ultimately not able to commit to the research over the longer term. All advisory members had experienced life on inpatient wards in the UK, with all but one having attended services within the local Trust. Despite the open eligibility criteria, all those who contributed to the research in an advisory capacity were women.

Each member was compensated for their time, reimbursed for travel, and given refreshments during in-person meetings. Issues discussed with the SUAG included: the role of the group; feedback on participant information sheets; advice on the interview protocol; advice on engagement with staff management; the analysis of data; and how to ensure appropriate and sensitive recruitment of service users. Advice was sought on what findings might be of most practical interest and how they might best be disseminated to the public and practitioners.

Although the SUAG involvement was valuable throughout this research, two particularly noteworthy phases are highlighted. First, the SUAG assisted with the development and refinement of the interview schedules employed in Stream 1. The SUAG was also instrumental in assisting the creation of the formulation model developed for this research, the PNM, which is described in detail in Chapter 7. Finally, the SUAG assisted with the analysis of the service user interviews described in Chapter 6; their feedback and the resulting analysis are described therein.

4.6 Summary

Critical realism was chosen as the philosophical framework for this research. Briefly, this stance entails the belief that an objective reality exists but that our knowledge of it as humans is fallible and we may never reach it. However, we can come closer to reality through our best guesses (theories) that we devise through an assortment of evidence from as wide a base as possible. PPI entails both moral and efficacy-based arguments and was employed in this research through a SUAG, who contributed throughout.

5. Chapter 5 Staff Interviews

5.1 Chapter Overview

This chapter reports on the Stream 1 case study findings of staff interviews as outlined in 3.4.1. In Chapter 2, the literature relating to staff experiences of inpatient services and specialist inpatient services were presented. This phase of the research intended to explore an exceptional case of positive practice within a specialist inpatient ward, Poppy ward (see Chapter 1). The opportunity to explore the conditions that allow for positive experiences adds to the current body of literature.

Little evidence exists to indicate how recovery is supported within services, and particularly within specialist services for individuals with a diagnosis of personality disorder (Donald et al., 2017). Poppy ward advocates for SDM and PRT, both believed to endorse service user empowerment. By exploring the experiences of staff related to their application of these principles, it is possible to further investigate how recovery principles can apply to specialist services for BPD.

The aim of this research was to explore staff experiences of care on a positive practice ward (see Chapter 1).

The research question explored in this research was:

3. What factors do MDT staff believe are involved in the operation of Poppy ward as a positive-practice specialist ward for service users with a diagnosis of personality disorder?

5.2 Context

See Chapter 1 for a full description of Poppy ward.

5.3 Methodology

The rationale for undertaking an embedded case study approach along with other philosophical rationale and details are outlined in Section 3.3.2.

Briefly, given the nature of the research question and desire to access rich, in-depth data relating to the operation of a positive practice specialist ward, a case study design was chosen (Yin, 2013). Interviews were chosen to provide insight, explanations and a personal account of meaning and attitude (Yin, 2013), and semi-structured interviews were selected to

guide a discussion that addressed the research question whilst allowing some scope to pursue topics of interest to the participant.

The interview schedule was developed according to a review of the literature related to positive practice and qualitative research (Crotty, 1998; Fischer, 2006; DiCicco-Bloom & Crabtree, 2006; Green & Thorogood, 2018; Harrell & Bradley, 2009; Morgan & Smircick, 1980) as well as input from my supervisory team and the SUAG. Questions were formulated relating to: 1) how staff develop an understanding of service users' challenges and/or needs; 2) perceived enablers and barriers to change; and 3) how staff prevent or manage coercive practices.

5.3.1 Procedure

Interviews ranged in length from 16 minutes to 34 minutes. Prior to the interviews taking place, I sent the ward manager copies of the Participant Information sheets and Informed Consent forms (Appendix D) to disseminate these to staff on my behalf. I verbally explained these documents to participants ahead of the interviews and each participant signed a consent form prior to taking part in the research. Participants were debriefed following the interviews.

5.3.2 Participants and Recruitment

Recruitment of staff participants involved my attending two staff meetings to introduce myself and the research. At the second meeting, I handed out a sign-up sheet for staff to indicate their interest in participating (10 signed up). Alongside the ward manager, I identified times during the working day when the maximum number of staff would be available, including during handover and when weekly educational sessions were scheduled. The ward manager then booked an available room with the ward administrator, and they would then either email the team to alert them of my presence or announce it during their morning meeting.

While Terry and colleagues (2017) recommend 15-20 interviews for a PhD project whose RTA data represents only part of the entire thesis, this was not possible in this research; as agreed beforehand with Poppy ward's gatekeepers, 10 staff was the target number of interviewees given the limited time and staff availability within the inpatient ward setting. Thus, participants were 10 Poppy ward staff members whose roles involved one-on-one therapeutic interaction with service users.

5.3.3 Ethical Considerations

Section 3.7 provides details relating to the overall approach to taken in this research. Pseudonyms were assigned to service users to retain their anonymity. The decision was made not to specify the role of more senior staff (identified instead as 'senior staff member') given their fewer number and, as such, higher vulnerability to identification, particularly by other participants.

5.3.4 Transcription of Interview Data

I transcribed verbatim the audio from each participant's interview. I carried out the transcription myself to become adequately familiarised with the data (see stage one of thematic analysis described below). All spoken words were included. The decision was made here to include some features of speech, including hesitations (demarcated by a '[pause]'). However, the interviewer's 'guggles' (noises demonstrating understanding or acknowledgement; Hayfield et al., 2019) were removed. '[...]' indicates the removal of excess detail or potentially identifying details from the data (Clarke & Demetriou, 2016).

5.3.5 Strategy for Data Analysis

Analysis followed the process of RTA as described by Braun and Clarke (2006), which involves six phases: familiarisation with the data (listening and re-listening to the recordings; reading and re-reading the transcripts); generating initial codes (taking notes during the familiarisation process); searching for themes (revisiting codes, collating similar codes and identifying common meanings); reviewing themes (comparing data to themes, and attempting to strike a balance between themes relating to one another without being 'too distinct'; Terry et al., 2017); defining and naming themes (constructing a story about the data that captures its complexity and patterns; Terry et al., 2017); and finally producing the report. There was some degree of iteration where, for example, writing the report led back to defining and naming the themes followed by writing the report once again. In line with the 'Big Q' RTA orientation, I aimed for transparency in my role in the development (as opposed to 'discovery') of the themes presented in the following analysis. Equipped with the same research question, another researcher may well have concluded with different themes; similarly, 'data saturation' was not a goal, nor is it relevant to the approach taken in this

research. For further contextualisation of the research approach I took and an interpretation of the results described below, see Section 1.5 for a reflective statement.

A critical realist framework guided the analysis; thus, attention was paid to both semantic and latent aspects of the data. The analysis was largely inductive, with the data itself guiding the development of the themes.

5.3.6 Procedures for Assessing the Quality of the Analysis

To demonstrate the merit of this work, both Yin (2013) and Braun and Clarke (2020) were consulted to determine the features or steps indicative of high-quality work. Beyond providing justification for my methodological decisions (see Chapter 4), I have 'owned my perspective' in Chapter 1, which is of particular importance where the researcher is an 'outsider' to the group researched, according to Braun and Clarke (2020). Care was taken to ensure conceptual and theoretical coherence throughout this work (for example, no 'codebooks' or mentions of 'generalisability' are made). Finally, Poppy ward staff were consulted in June 2020 regarding their views of the validity of the themes; positive feedback was given, and no themes were objected to.

5.4 Demographics

Demographic data was collected later in the research process, during Poppy ward staff training. Given the difficulties arranging continuity of participation (see Chapter 7), the demographic information of only six of the 10 interviewed staff was collected. Four participants who identified as female and two as male took part in the research. On average, participants were 37 years of age, ranging from 23 to 53 years old. Participants had undergone 4.83 years of training on average, ranging from two to 15 years, with an average of 8.47 years of clinical experience (ranging from .83 to 14 years). Participants had been in-role for an average of 3.78 years, ranging from six months to 12 years and working at Poppy for an average of 3.89 years (ranging from .83 to 7 years). Participants were from a wide range of professional backgrounds with one each of the following roles: deputy ward manager, ward manager, clinical nurse specialist, consultant psychiatrist, HCAs, and nursing associate.

5.5 Results

Before interpreting the findings, readers are advised there was some evidence of service users being seen by staff through the lens of their diagnosis (for example, generalising

statements relating to service users) while others evidenced more individualising views, indicating the goal of treatment is to see beyond the diagnostic label. In DBT terms, this represents a dialectic. Staff members with greater seniority tended to demonstrate increased willingness to be critical of processes, although this was not consistently true. Many staff made comparisons to other wards, framing Poppy ward as superior.

Three superordinate themes were developed and are fleshed out in detail below (see Table 5.1). These include (a) 'really, really good' relationships, (b) culture of empowerment, and (c) team support and development. It is important to note that while the following themes are focussed on positive reflections on ward practices, they are balanced throughout by more critical perspectives.

Table 5.1

Summary of Staff Interview Themes

Theme	Subtheme
Really, Really Good Relationships	Community
	Relationships With Unqualified Staff
	Enablers of Good Relationships
	Barriers to Good Relationships
Culture of Empowerment	Reclamation of Responsibility for Risk
	Collaboration and Involvement
	Barriers to Empowerment
Team Support and Development	Staff Supporting Staff
	The Value of (Ongoing) Education on Personality Disorder
	The Value of (Ongoing) Education on DBT
	Securing Your Own Mask Before Assisting Others

5.5.1 Really, Really Good Relationships

This theme captures the emphasis participants placed on the relationships they experience within the ward at community, therapeutic and human/personal levels. Participants described how Poppy ward service users are assigned a core team, with the traditional primary nurse allocated as their key worker, as well as an associate nurse, an HCA

and a DBT therapist. Each shift, a service user is allocated a named nurse, or a particular staff member to speak to. Enablers and, to a lesser extent, barriers, were identified in relation to the development and maintenance of these relationships.

For this ward, relationships represent one of the most important factors in cultivating a therapeutic environment and the effective functioning of the ward. Within this relational theme, the subordinate themes were, 'community,' 'relationships with unqualified staff,' 'enablers of good relationships,' and 'barriers to good relationships.'

5.5.1.1 Community. A feeling of community was reported to be actively fostered on the ward such that relationships between all individuals on the ward were thought to be equally good. A senior member of staff, Brandon, indicated, "I think all staff have a relatively good relationship with all the patients if you see what I mean […] we strive to make sure all staff and all the patients [know each other]".

Staff feeling confident in their equal understanding of all service users was a sentiment commonly reported. For example, Ariel reported, "I think-I think we all know the patients equally well," and Christopher reported "I think everyone knows everyone quite well, actually."

Participants described structures in place that support this, such as a randomised rota of staff responsible for particular service users for the day. As stated by Emily, "[I] get to know everyone on a one-to-one basis anyway… I wouldn't say I particularly know [particular service users] any better than any of the others". Daily community meetings also took place with service users and staff at all levels. In Bree's words, "We all have a community meeting in the morning where we all talk to each other every day and the evenings".

Staff also reported a flattened hierarchy amongst the MDT and a feeling of community or unity. As stated by a senior member of staff (Brandon), "The most important part of the ward, really, is interpersonal relationships, debriefing staff. We're a single community rather than two divided groups."

The community ethos was found to extend to relationships between discharged service users and the ward. For example, discharged service users attend 'social teas' on Fridays. As stated by another participant:

> Patients who have been discharged and are back in the community are welcome to come along to that and just kind of keep in touch and-and share their learning with other people […] it's a way to kind of keep those connections there. (Grace)

An ongoing relationship between discharged service users and the ward was deemed important by a senior member of staff (Brandon): "[Relationships are] ongoing. I don't see people as non-patients or ex-patients and-[…] Whoever's willing to come [to social tea]– everybody's able to come back and say hello, really".

A senior member of staff (Juniper) clarified service users returning may serve to be socially therapeutic: "that relationship's still there […] Um, obviously not in a supportive way […] But it's nice for them to come back and […] And that helps them". In a similar way, staff also encouraged discharged service users to embrace their lived experience and capacity to aid other service users. A senior member of staff elaborated on this:

> It's potentially a perspective that a patient's moved from their sort of working patient role to the ex-patient role […] And-and I imagine there's a shift within their understanding […] Of the working relationship if you see what I mean, so if you come back as the expert. (Brandon)

5.5.1.2 Relationships with Unqualified Staff. Despite a reportedly good level of knowledge and familiarity amongst all on the ward, service user and staff alike, the unqualified members of staff (HCAs) interviewed indicated a particularly strong relationship with service users.

One HCA, Emily, emphasised the majority of their working day is spent with service users:

> I am probably, if you like, one of the people who spends the most time with our client group on a daily basis, so I generally […] am, you know, apart from small amounts of time within meetings and in the office where I might have to write some notes and things, I will generally be on the shop floor. (Emily)

Compared to other staff, the extended time HCAs spend with service users was thought to lead to a deeper or different kind of understanding.

Some unqualified members of staff felt that because they spend more casual time with service users, they can develop a deeper understanding of these service users. In describing their ability to develop understanding of service users, one HCA, Una, stated:

> You find out more about people and…[in] a more informal environment, you're more natural … some people have found it hard when their kind of therapist isn't a ward-based member of staff…it's easy to build that kind of rapport and relationship in a much more informal way. (Una)

The informal environment described by Una was elaborated to include weekend activities away from the ward, such as trips to the zoo or dinner together, which may serve to break down any barriers potentially imposed by a professional identity that might otherwise manifest in the context of a ward, (for example, staff versus service user).

5.5.1.3 Enablers of Good Relationships. Staff described informal activities undertaken by both staff and service users as supporting the development of stronger relationships. Specific activities were described: Bree spoke of a recent camping trip and recurrent "midday festivals and things like that." Una described how other activities and time spent together can replicate 'normal' life for service users.

> So I think it's every Tuesday afternoon, we have our, like, out-and-about group. Um, for about 3 or 4 hours- … we usually run that and usually I've got weekends as well, um, kind of taking them all out to the beach or anywhere, we went to the zoo not that long ago… out for dinner… It's quite nice to do stuff, like, normal- Family life. And what you do with, like, your friends. (Una)

The importance of time in enabling relationships between staff and service users was a recurrent theme amongst staff and viewed as being necessary for the quality of the therapeutic alliance. For example, one nurse, Grace, indicated, "You can build a really, really helpful therapeutic relationship with people because you're seeing them really regularly […] Uh, for quite an extended period of time". This was concurred by a senior member of staff (Christopher) "Over a period of time, you develop an understanding of the person and their-their difficulties and their situation".

Perhaps as a by-product of time, Grace described deepening their understanding of and relationships with service users through both difficult and joyful experiences:

> People are in here for a long time; you go through lots of ups and downs with people in terms of their-their own lives and you're there as a support so it really builds up that confidence to be able to come and talk when they're in distress. (Grace)

Some staff members indicated that time is especially important for service users with a diagnosis of BPD; however, it was pointed out by a nurse participant (Alexis) that this may

simply be true for anyone who is expected to engage with the vulnerability of others: "I suppose it happens [to] everybody: me, you, or anyone […] Before we can make that trust and confident being talking to someone, I think it would take us a little while".

An important facet of relationships was seen to be open and honest communication. This was considered integral to staff, particularly in engaging with service users. According to Bree, "Obviously with the DBT sort of stuff, they-not encourage staff disclosure, but, you know, we are… willing to be human". They further reported, "That radical genuineness is something that we try and hit home to staff. So [they do this] as soon as they step on the floor".

Staff particularly emphasized an open and honest approach when engaging with service users, who some described as being particularly sensitive to the ward's atmosphere or detecting where genuineness is lacking. Thus, they concluded the best strategy in engaging with service users is to "kind of come be honest" (Una). Another member of staff described particularly valuing "Being able to encourage [service users] to be open and honest" (Bree).

Some staff emphasized that all individuals on the ward, not just staff, should practice openness and honesty. As stated by Heather, "It's just, yeah, everyone just having a discussion-an open discussion about things." As Una described, "I think we do always say we try and kind of keep that open and honest environment".

Staff also appeared to emphasise the importance of openness and honesty in terms of avoiding conflict that may otherwise lead to the use of restraint. For example, one member of staff described that when service users approach staff for one-on-one time and staff are unable to immediately oblige:

> Even if there's a genuine reason why. I mean, I think you need to be honest with people, open, and talk to people and if you haven't got time, tell them 'I'-you know, 'I haven't got time at the moment.' (Ariel)

5.5.1.4 Barriers to Good Relationships. Barriers to good relationships were not prominent themes within the data; however, it is important to report any instance where a barrier has been raised to convey the range of perspectives more accurately and therefore provide a more complete picture of the data.

For example, the idea of a unitary community was also contradicted by Brandon: "it's interesting that very quickly we split into 'self' and 'other' as a staff group." Thus, perhaps,

the community sentiment promoted within the ward may be more difficult to maintain in everyday practice.

'Best fit' between service users and clinicians was articulated by a subset of participants as playing a key role in treatment efficacy. Despite the common sentiment that all people on the ward know each other equally well, there was also an acknowledgement that extra-therapeutic factors are involved in the success of therapy. This included, for example, a clash of staff and service user personality types. For instance, one unqualified member of staff (Emily) indicated the quality of the therapeutic relationship "will depend. Like, for whatever reason, maybe you don't click or maybe they don't particularly want to talk to you […] Individually and that's fine too (laughs)… Assign me to someone else."

The absence of best fit may, however, impact the quality of the service user's therapy, such as in service user disclosures of relevant aspects of a person's history or other aspects of their life. For example:

> Sometimes we'll find that some patients will discuss, like, one aspect of issues with one person quite a lot or two people, uh, and wouldn't necessarily mention that to you […] Depending on your relationship, I guess, with them. (Emily)

Ward politics may be at play in terms of playing 'hot potato' with a service user who behaves in ways that staff find challenging. For example, one qualified member of staff indicated:

> I know when I first started on the unit, I did sometimes get stuck with the unpopular patient [laughs] […] And you could see from daily allocations that the unpopular patient, they get staff members saying no least… So, and that's often the least qualified staff member. (Brandon)

Thus, there appeared to be something of a hierarchy or 'pecking order' for staff and a perceived desirability of working with particular service users; the two also appear to interact at some level. This was only remarked upon by Brandon; however, given their more senior role, Brandon was potentially privier to these dynamics from both having personally experienced it as well as having witnessed it in subordinate staff.

Whilst only a small subset of staff reported lack of service user engagement in therapy, this is nonetheless significant given how consistently it is reported to occur in the literature. Staff additionally observed that despite a lengthy pre-treatment phase in which service users are required to fully commit to the DBT programme and 'want to get better', that:

> Sometimes we'll get through a year, and we'll think, 'oh, we know them really well' and then actually, we're like, 'do we'?[...] It-kind of a lot of the time it can be quite, like, a front, having, you know, kind of like polite, everyday conversation-[…] And we'll get kind of six or seven months in and we think: 'we don't actually know that much.'(Una, HCA).

Staff who observed this phenomenon speculated this could be due to service users experiencing a legacy of what are often chaotic and overburdened inpatient treatment environments and feeling as if they could 'coast' and get away with only engaging on a surface level. For example:

> There's someone that has been here, like, six months and we're like, 'actually, we really don't know anything'… So it can be hard, because you think you know them quite well, and I think there is a few that you do…. Um, yeah, I think there's definitely a few that kind of sometimes can kind of sail along… And not really engage that deep. (Una)

Although staff generally felt they understood service users, they were less certain that service users feel understood consistently. Only one member of staff, Grace, responded unreservedly positively: "I think on the whole […] I-I think that they do feel understood, um, in this environment." More frequently in answer to the question of whether staff believe service users feel understood, staff expressed varying degrees of uncertainty. For example, one member of the ward management team stated in answer to the question of whether service users feel understood, "I would say you would probably get a different answer every time that you ask that question" (Bree).

Seven of the ten staff interviewed said that service users frequently express not feeling understood, although this was not generally taken to be a genuine sentiment, but rather a transient one.

> I think something we get thrown at a lot is kind of, you know, you don't care or you don't understand […] Um, but I think a lot of the time then that-when it's kind of spoken about after, it all kind of-it's more-it's more of a heat of the moment, I think. (Una).

Despite feeling at times that service users do not feel understood, these disagreements were thought to be resolved through open communication and dialogue. For example, as Emily stated:

> They say to us, here they feel more understood than any place, generally, that they have been. I think there are times where some of our clients might feel that they're being misunderstood […] And sometimes that is resolved by sitting down, but I-I would say generally overall that most of our patients feel quite-that they can, like, issues, conditions are understood. (Emily)

5.5.2 Culture of Empowerment

The superordinate theme 'Culture of Empowerment' describes the generally affirmative responses given by participants to questions relating to collaboration with service users and focuses primarily on the facets of empowerment represented in this ward as they relate to practice ethos and processes. Barriers were also explored although they represented a subset of the response given. Subthemes explored are 'reclamation of responsibility,' 'we are patient-led,' and 'barriers to empowerment.'

5.5.2.1 Reclamation of Responsibility for Risk. Traditionally, ward staff act as custodians on the ward and are responsible for ensuring service users' safety and security. This ward appeared to have eschewed this approach and sought to reassign responsibility and agency to service users. Service users were particularly encouraged to take responsibility for their safety on the ward, not only for ethical reasons but also for pragmatic reasons of treatment efficacy. As stated by Juniper, a senior member of staff, "[staff] give them the responsibility in their own safety [...] And we have much better outcomes because of it."

Staff indicated the service users they work with are often surprised by this transference of responsibility for their own safety. For example, if a service user should experience thoughts about self-harm, staff ask, "what can you do to keep yourself safe, or what can you do next time, so kind of reflect it back on them […] Yeah (laughs) I think it shocks them" (Una, HCA).

Staff also indicated that a proportion of service users they work with have a lengthy history of inpatient treatment, some coming directly from child and adolescent mental health services (CAMHS) which are largely directive and paternalistic given their role as primary caregiver (Mulvale et al., 2019). Thus, some service users have limited experience of making choices for themselves and even struggle with the concept. As one member of staff (Una) put it, "I think they've never been given the responsibility of- […] Kind of day-to-day life." The transference of responsibility may be especially important for service users who have spent long period of time institutionalised. One staff member (Emily) suggested this may make up a large proportion of service users admitted to the ward: "most of the patients that we accept

or get referred here, you know, have been in the system for a long time," and are "career patients from when they were teenagers."

5.5.2.2 Collaboration and Involvement. The admission criteria for the ward ensures service users are voluntary attendees. A senior member of staff indicated this is not only for ethical reasons, but for the efficacy of the programme: "They come informally mostly, but we do get detained patients as well. Um, but we quite quickly try and remove that section because we find in the past that …having to engage in the program to get better doesn't work as well as wanting to get better" (Bree). As Juniper concluded, "we find that putting sections on patients is really not beneficial – at all."

One of the chief tenets of DBT and the extensive pre-treatment phase is to promote this way of thinking: "having to engage in the program to get better doesn't work as well as wanting to get better" (Bree). Instead of services asking, pressuring, or coercing service users to engage, DBT requires service users to want to participate and to agree to particular terms of this participation in advance of therapy (Linehan, 2018). Thus, responsibility to engage with the programme is transferred to the service user. As stated by Brandon, "If the patient is to stay here it's down to them to stay voluntarily."

In relation to care practices once the service user is admitted, general NICE guidelines (2012) for treatment of adults in inpatient services directs services to engage with service users in making decisions around their care. NICE's 'Principles of care for people with a personality disorder' (2020) additionally prescribes those services assist services users with a BPD diagnosis by promoting active involvement in exploring solutions to challenges and any potential consequences.

Staff reported that active collaboration with service users is encouraged in everyday practices, including ward rounds, which one participant used as an example of when and how service users' autonomy over treatment is demonstrated. As stated by Juniper, "Every two weeks they'll have a ward round where they get to discuss any issues with their medication, or, um, the program itself. Is there anything that's not helpful or helpful they want to change."

Participants described involving services users in the care-planning process. One participant summarised the general sentiment expressed by staff regarding involvement of service users in their care, particularly as it relates to care-planning:

> Involve [service users] in their care-planning. It's no good saying, 'well, uh, your care, that's all the problem[/s/] you have'[…] 'This is your-a goal you want to achieve and that's how we're doing it.' We don't make that decision. We get them to come with us and involve them and they participate in their own care-planning. (Alexis).

Another staff member expressed the same sentiment, "Making it more person-centred and what they need… Out of the admission, instead of us forcing what we're gonna be doing" (Heather).

Similar to service users being encouraged to take responsibility for their safety, some staff indicated service users are equally responsible for their care plans: "I think it is quite reflected back on the patients to make their own care plan" (Una).

The whole-team approach to promoting active service user engagement with respect to their care and the unanimous support for this approach counters less positive portrayals in the literature. In research conducted by O'Donovan (2007) on a ward providing care to service users demonstrating behaviours of self-harm, it was reported that service users lacked choice in their care, and choices were only made available to those who asked.

All staff agreed the care-planning process is collaborative. Particular processes described to promote the voice of the service user in care-planning was the use of service-user quotes, for example, as stated by Bree: "Basically, um, the primary nurse will meet with the patient once a month. They'll do it together. It's supposed to be patient-focused; it should contain direct quotes from the patient."

Staff indicated this inclusion serves to convey the service users' perspective as closely as possible given the current process. As stated by one participant, Grace:

> I think it's always helpful to have quotes from people, because then you get a real sense of what it is they're feeling; it is very easy to say, oh, 'they describe their difficulties as this,' but is that my own interpretation of what they're saying? (Grace)

An additional process within care-planning related to service users checking the accuracy of the written care plans. Once staff and service users discussed what should be included in the care plan, staff produced a digital and carbon copy, which was then given to the service user to read and correct. "And then we change it all on the computer again, then give it to them and they agree with it, they sign it" (Alexis).

At this stage it is interesting to reflect on the tension between service users 'directing' or being 'in charge' of their care-plans versus collaborating with staff as equals. This was not discussed with the interviewees themselves; however, collaboration often appears to often be

conflated with ‘client-led.’ The question thus remains as to whether staff conceptualise service user involvement or collaboration versus practicing in a way that is client- or person-centred. Are they the same, and, if not, what are the key distinctions? Additionally, which one is possible or preferable for services and what are the parameters relating to service users making decisions on their own (Castillo & Ramon, 2017)?

5.5.2.3 Barriers to Empowerment. Despite most staff agreeing the care-planning process is collaborative, a select few members of senior staff expressed doubt concerning the usefulness of the resultant care-plan. While these responses are few and expressed exclusively by senior members of staff, it feels important to highlight contradictions within the dominant (positive) narrative. One senior member of staff suggested that bureaucratic requirements, such as those outlined by the Care Quality Commission (CQC) significantly compromise the relevance of care plans:

> Even though we’ve been reassured we don’t do it for the CQC, we’re building a model of care for the CQC who come in and take a snapshot of it, aren’t we? … And I think that inhibits our work. (Richard).

This participant went on to suggest that despite the use of quotes and speaking to service users directly to ensure their perspective is properly represented, the use of quotes may, in effect, be tokenistic given how irrelevant and impractical care-planning guidelines can be.

Effectively, the dominant view of the CQC guidelines was scepticism as to whether they could produce care-plans of any practical relevance for stakeholders, and in particular for services users; however, as NHS wards rely on CQC ratings to demonstrate their efficacy, there is little choice but to adhere to these guidelines. One senior member of staff, Christopher, indicated, “I’m not particularly proud of what the care plans look like in modern times. Uh, the-they are cumbersome, long-winded documents that serve the purpose of satisfying the audits, but not really are of much use […] For the patient.”

Thus, staff felt these guidelines, which are intended to facilitate enhanced quality of care, in reality, impede it: “The Trust and the ward and everything else is, I suppose, judged, effectively, on the quality of the care plan. But at the moment we probably have care plans reflecting what the Trust wants us to ask” (Christopher). Further, there is the potential for current care-planning processes to obscure good practices:

> I genuinely think we are patient-led but it's really difficult for the care-planning process to demonstrate that… I think service-users should be saying 'this is-this is what my care looks like'… And how do we facilitate this?... Rather than us saying, 'this is what your care is going to look like and how we're going to engage you. (Brandon).

Christopher agreed, saying care plans:

> So after admission, the patient will complete a care plan with their named nurse; so every patient will have a named nurse. Yeah, uh, a document is produced, printed, and signed by the patient. Um, I don't think it's that useful. (Christopher)

Despite the frustrations posed by the misdirection of audit-compliant care plans, one staff member (Brandon) indicated "we could build really collaborative, and patient-led care plans […] Without too much of a change at the moment." Brandon went on to describe a similar frustration with the risk-assessment process and their individual proposed remedy to widening the focus from the service user to their broader context:

> The current risk assessment formulation process within that doesn't really have formulation. It's a tick-box approach to, 'are you going to kill yourself? Yes/no'… Uh, I'd like to see more formulation work for each service user… I've been using ABC – the ABC model [a CBT formulation model] with some service users regarding incidents [inaudible segment] staff, and that seems to go down – seems to go down alright… And maybe if we changed our perspectives to, I don't know … the patient and the situation around them… Rather than the patient and what they might do. (Brandon)

While acknowledging the difficulties of doing so, Richard seemed to suggest that moving away from a rigid, inflexible 'tick-box' approach to care-planning, risk-assessment or formulation is a potential solution to the frustrations experienced.

5.5.3 Team Support and Development

Staff spoke favourably about the systems and supports in place to bolster their development both individually and as a team. Indeed, underlying their talk of relationships and empowerment of services is a ward whose culture prioritises supporting service users by supporting the staff. Team Support and Development is woven through the relational realm, through to attitudes, and throughout practical everyday practices and processes. The subthemes are 'Staff Supporting Staff,' 'The Value of (Ongoing) Education on Personality

Disorder,' and 'The Value of (Ongoing) Education on DBT,' and 'Securing Your Own Mask Before Assisting Others.'

5.5.3.1 Staff Supporting Staff. Staff supporting staff was another prominent theme to develop. Staff at all levels are reported to be included in care discussions. Collaboratively, the staff team discusses and makes decisions, as stated by Christopher:

> We discuss things on a regular basis. We also […] if needed, collaborate with other, uh, units or other consultants, uh, for second opinions if needed. Usually about co-morbidities. Um, but yeah, there's no one in the team that doesn't contribute in some way. (Christopher)

Ariel affirmed this practice, "Um … everybody [is] involved in the person's care".

Staff viewed their relationships with each other as supportive, bolstering and reassuring one another. One senior member of staff, Bree, encapsulated this:

> Making sure that your staff feel listened to on this ward is really, really, really important with this client group are extremely difficult and challenging on an everyday […] So if we're not supporting our staff from the top down, then that's going to be reflected on the patient. And the staff relationships. (Bree)

Two staff members additionally spoke of a culture of PRT and the importance of feeling supported to practice PRT successfully. For example, "I'd like to think we're generally risk-yeah, we're sort of positive risk-taking […] least restrictive ward" (Brandon). Another staff member, Grace, reported that:

> Whatever decision you make, you know someone's gonna back you up […] And have-be in your corner period. Um, and the-there's a culture of positive risk-taking here so people aren't kind of afraid to stand up for the patient and say actually, we should let them out. (Grace)

In terms of care-planning, staff indicated that members at all levels of seniority contribute, as stated by Heather:

> We should all really be sort of contributing to care planning as a team […] It should be all of us. Um, who's coming in contact with the individual […] we should all be really having a sort of a go at it […] That's how we sort of describe it" (Heather).

Some of this support appears to emerge from regular contact with one another: regular meetings, including "three handovers [pause while counting] four handovers in a day" (Alexis). This is in addition to a daily community meeting to which all team members are welcome. These meetings were reported to allow staff to access support in their work with service users and for the whole team to be aware of any particular difficulties. For example, according to Heather, "We have regular team meetings around sort of if we're finding things difficult, what's going well, stuff like that, if we need help with a certain service-user."

5.5.3.2 The Value of (Ongoing) Education on Personality Disorder. Educational sessions, including continuing professional development, are viewed as important in the literature for developing skills and competencies (Davies et al., 2014). Ongoing staff training was referred to as particularly important, and structures are in place to support this, such as a dedicated weekly 3-hour block of time to support staff education: "On a Friday we have our 2 o'clock meeting, which is quite open and we use it for staff education on a Friday" (Juniper). Given the demands of the inpatient ward environment, this 'protected time,' as it seems to be described, may be indicative of the priority given to continuing education and ensuring the currency of knowledge. It is unclear, however, how this works logistically given the need to maintain sufficient staff numbers to tend to service users' needs.

Staff on this ward at all levels of seniority heavily emphasised the importance of continuing education; exposure to new ideas, including conference attendance; academic journal articles, and consulting with and for other professionals relating to clinical challenges. A nurse participant (Grace) reported that all staff are keen to maintain their knowledge related to evidence-based practice: "A lot of the team here particularly are kind of keen to keep up-to-date, so we go to lots of conferences."

Some staff described pursuing additional or intensive training to improve their subject area knowledge or other innovative ways of understanding or working with individuals with diagnoses of personality disorder. This aligns with the conclusions of previous research exploring educational needs of staff, including workshops, attending conferences, and in the case of two members of staff, pursuing postgraduate degrees in mental health. For example, a senior member of staff indicated "I'm currently studying a Master's in personality disorder."

A particular focus on education has been placed on dismantling pervasively negative cultural attitudes towards individuals with diagnoses of BPD which aligns with the recommendations from the literature on creating cultural change (Mack, 2016; O'Connell &

Dowling, 2013; Woollaston & Hixenbaugh, 2008). As observed by Mack (2016), staff may be exposed to negative attitudes towards individuals diagnosed with personality disorders before receiving formal education. Encouragingly, training to address negative attitudes toward individuals with a diagnosis of personality disorder has demonstrated efficacy (Beryl & Vollm, 2017).

One senior member of staff (Brandon) described the ward's approach to implementing this training:

> Staff come to the ward with a whole host of preconceptions and, uh, prejudices toward the patient group, which is probably an unconscious bias level from previous environments […] It's a lengthy process […] staff are able to build a basic awareness […] Of challenges that people with borderline face, then-then they can be more empathic-empathic in terms of treatment. (Brandon)

The Knowledge and Understanding Framework (KUF) was first introduced in 2007; its initial aim was to challenge misconceptions surrounding individuals with a diagnosis of BPD. The KUF was collaboratively developed alongside service users and encourages its delivery alongside experts by lived experience (Davies et al., 2014). It was frequently referred to by staff:

> [I] think nearly everyone on the ward's done [the Knowledge and Understanding Framework training]. So that was all about personality disorders and kind of making sure everyone was on the same level of knowledge and understood […] The background behind it. (Una)

This was affirmed by both nurse and service user members of staff, exemplified by Grace: "Lots is done on the Knowledge and Understanding Framework […] Training, which is aimed at how to really understand the challenges of borderline personality disorder and personality disorders in general."

5.5.3.3 The Value of (Ongoing) Education on DBT. In a similar vein to the previous sub-theme, Poppy ward staff emphasised the importance of training, although a separate emphasis was placed here on DBT. Specific priorities involved maintaining DBT skills and keeping up with the latest published evidence.

As articulated by a senior member of staff, "So everyone will have different treatment priorities-training priorities, but the ward has to provide DBT" (Christopher). One nurse participant (Grace) echoed this: "Everyone's kind of really up-to-date in what is current in

the evidence base. Also, quite highly trained in DBT. The =senior role=’s got a post-graduate qualification in DBT, so =they’re= very knowledgeable in that area”. Staff reported trying to ensure their knowledge of is current and robust, perhaps given, as Christopher indicated, referring to DBT: “that’s important. That’s part of the program brand.”

Once again emphasising that knowledge of DBT extends to all ward staff, Ariel indicated, “All the nurses are DBT therapy-trained. Um, all new nursing staff that come onto the ward, uh, will do that, uh, at some point. Um, most of the staff on the ward are DBT skill-trained. Um, that’s all ongoing.”

Enablers of training delivery on this therapeutic approach are the resources available to this ward which facilitate additional and universal training at least at a basic level. As indicated by Bree: “We’re just about to train the new healthcare assistants in skills, so that they can learn to support the DBT therapists on the ward. We’re quite lucky that we have an out-of-area budget.”

It is possible that education works to enhance staffs’ confidence in the therapeutic value of their work and the impact they have. For example:

> It took a little while, but um we have quite a lot of educational stuff as well and I already knew quite a lot about mental health in general and our client group, so […] yeah, I’ve-I’d say I feel quite confident. (Emily).

Qualified members of staff tended to frame their knowledge of service users with their knowledge of DBT or previous professional experience. For example, knowledge at a clinical level was demonstrated by one staff’s description of how they develop an understanding of a service user “by reading their previous history, read their notes, you can talk to them, getting to know them and whatever questions I need to ask” (Alexis).

Similarly, other staff members relied on their previous experience, skills and training in developing an understanding of service users. For example, one qualified member of staff indicated they tend to develop an understanding of a service user “in terms of other people I know about. I think I’m confident of what helps deal with a particular set of problems […] And what doesn’t help.” (Christopher). Similarly, another member of staff referred to their work experience with individuals diagnosed with BPD: “I think seven years working with this client group does give you a steady base […] To feel confident in their needs” (Bree).

One member of the ward management team (Bree) specifically emphasised the importance of training in DBT, referred to in the literature as a therapeutic framework: “I

think overall, the staff have a really good understanding of the patients. We've spent quite a bit of money training people in DBT."

5.5.3.4 Securing Your Own Mask Before Assisting Others. Supervision is a process which accountably supports the development of skills, knowledge, and values of a team (Skills for Care and the Children's Workforce Development Council, 2007) while reflective practice is learning through experience using reflective modes of thinking, which can help develop a culture of 'psychological mindedness' integral to competent practitioners (Fenton & Kidd, 2019; Heneghan et al., 2014; Mann et al., 2009). Both supervision and reflective practice were indicated to be necessary supports for Poppy ward staff.

On this ward, supervision was a prominent subtheme in supporting good practices and ensuring staff feel able to express frustrations and share strategies for dealing with challenges. As described by Bree, "[the promotion of a therapeutic environment] it's through supervision… Clinical supervision, operational supervision" which she said was particularly important in working with individuals with a diagnosis of BPD, who she felt could pick up on subtle shifts in staff behaviour or mood: "It's supervision, it's management of boundaries, um, making sure that your staff feel listened to on this ward is really, really, really important with this client group are extremely difficult and challenging on an everyday… basis."

Other staff (Christopher) indicated that supervision in combination with training in managing working with service users is key: "Everyone receives training and regular supervision. That's really quite important." Brandon concurred: "my thing is supervision and education be delivered side-by-side kind of."

Practices such as supervision and reflective practice are cited as especially important as they provide regular opportunities for staff to build competence and confidence working with service users (Webster et al., 2020). The literature indicates the absence of supervision and reflective practices may lead to clinicians feeling their sense of control or efficacy is challenged which may lead to labelling certain patients as 'difficult' or 'untreatable' (Beryl & Volm, 2018).

5.6 Discussion

This research set out to address the following research question: "What factors do MDT staff believe are involved in the operation of a positive-practice specialist ward for service users with a diagnosis of personality disorder?" The results addressed the question

through the development of three themes: (a) really, really good relationships; (b) culture of empowerment and (c) team support and development.

Several important and unexpected findings stand out, the first being the emphasis placed on relationships. This, in itself, is not novel (see Chapter 2; Acford & Davies, 2019; Bowen, 2013). Relationships are reported as integral to the experience of treatment (Gilburt et al., 2008) and have been suggested to be a key non-specific therapeutic factor in assisting service users to recover. However, participants involved in this research reported ubiquitously good relationships across all staff and service users, or a 'community' environment, which is not often reported in the literature. This idea of community, however, bears some resemblance to the ideas espoused by therapeutic community, which can be traced back to the 18th century's 'moral treatment' (Whiteley, 2004). As an orientation, therapeutic community entails a set of principles in which the holistic needs of staff and service users are of central importance (Mistral et al., 2002). A therapeutic community seeks to establish a democratised and de-institutionalised way of being between staff and service (Mistral et al., 2002). In short, therapeutic communities emphasise being human (Haigh, 2005), similar to the practices described by Poppy participants.

That HCAs are responsible for a high level of service user interaction while nurses and other qualified staff are responsible for administrative activities has been reported elsewhere (Bee et al., 2006). However, the informal relationships fostered by extended time spent together as well as activities such as weekends away and dinners out were thought to enhance the connection between unqualified members of staff and service users. Although according to this account, more senior members of staff do not spend the same amount of time with service users, they too indicated spending time interacting informally with service users, such as going to midday festivals and the like. An emphasis on informal relationships, relating to one another on a more human level, appears to be a relatively novel finding, although Laugharne and colleagues (2012) found that service users with a diagnosis of psychiatric disorder also appreciate a 'personal touch' in their interactions with staff (for example, staff sharing details about their family life).

An important facet of relationships was reported to be open and honest communication. This was considered integral to staff in engaging with service users and may be related to validation as a pillar of DBT therapeutic practice (Linehan, 2018), where one facet of validation is radical genuineness. As described by Sullivan (2018), this refers to the practice of responding to a service user as the practitioner would "to anyone else in his or her

life" (Swales, 2009, p. 167). Other research has emphasised similar qualities (Gilburt et al., 2008).

Time was reported as a key enabler of good relationships, given that service users undergo two six-month DBT treatments before they are discharged. This is not a dominant theme in the literature relating to positive practices or otherwise, possibly because a year-long inpatient stay is not a common protocol in the NHS, particularly for inpatient wards. At odds once again with existing research (Simpson et al., 2017), all participants reported collaborative implementation of care, which was described as guided by service users' needs. In the wider literature, the benefits of engagement with service users are acknowledged (Acford & Davies, 2019) but not implemented consistently (Slade, 2017). Generally, only two senior members of staff reported critical opinions relating to the ward's operations, particularly relating to care-planning, which they felt was overly bureaucratic. The need to adhere to CQC and NICE guidelines relating to care- and risk-planning were thought to result in a 'box-ticking' approach that impedes meaningful collaborative practices with service users and prevents a more individual and recovery-oriented approach.

The 'culture of empowerment' theme, particularly in relation to service users taking on responsibility for their own recovery and risk, addresses the recommendation made by Plamping (1998), who argued that a legacy of an "I am responsible" attitude from the early days of the NHS leads to struggles for dominance on the parts of individuals as well as compromised teamwork and interagency cooperation. The finding that Poppy staff report a commitment to a PRT through collaboration with other staff members as well as service users offers a heartening exception to this trend: Poppy staff encourage service users to make their own decisions relating to their recovery and safety, such as leaving the ward. This stance is particularly contradictory to the risk-averse position generally taken by NHS services (Stickley & Felton, 2006) where, traditionally, ward staff act as custodians on the ward and are responsible for ensuring service users' safety and security; an approach which has, in the past, been critiqued as paternalistic (Coulter, 1999). By transferring the responsibility for risk, staff are, to some degree, effectively stepping away from their custodial role. This is an exceptionally risk-positive attitude considering that service users with a diagnosis of BPD are framed as particularly risky (Johnstone, 1997); however, research does show that added freedom leads to improved recovery (Reddington, 2017) and staff clearly feel empowered by taking this position.

Poppy ward staff's emphasis on ongoing training relating to the diagnosis of BPD and DBT were interesting as ward structures were reported to support this, with weekly dedicated

time devoted to educational sessions and staff reporting an interest in education beyond the ward. The report that supervision and reflective practice maintain smooth operations is also noteworthy in its departure from existing literature, where at least a proportion of nursing staff find it to be without merit given its general lack of problem-solving (Cleary & Freeman, 2009).

Participants placing a high value on ongoing education aligns with previous research findings; according to staff, areas of opportunity for improved engagement include additional training and opportunities for professional development (Bergman & Eckerdal 2000; Bowen 2013; Commons Treloar, 2009; Dickens et al., 2016; Hazelton et al. 2006; Kale & Dantu, 2015; McGrath & Dowling 2012; Woollaston & Hixenbaugh 2008). Education may also play a part in supporting relationships between staff and service users by supporting positive attitudes towards service users with a diagnosis of BPD (Commons Treloar, 2009).

Relating to Poppy ward staff valuing regular opportunities for supervision and reflection, in the existing literature, recommendations to improve clinical supervision are found to be lacking on most inpatient wards for individuals with a diagnosis of personality disorder (Kale & Dantu 2015; McGrath & Dowling 2012; O'Connell & Dowling 2013, Warrender, 2015). Some studies report that specialist services require advanced access to education, training and resources which are hampered by service constraints including time, teamwork, workload, and financial restrictions (Bowen, 2013; Commons Treloar, 2009; Forsyth, 2010; Stroud & Parsons, 2013). That Poppy ward appears to 'protect' this time signifies a true commitment to its practice. Bowen (2013) suggests that adequate supervision and training as well as a shared vision of treatment can lead to the development of empathy, the 'active ingredient' in recovery promotion. It is also possible that staff on Poppy ward, by virtue of being supported emotionally and professionally through practices such as group supervision and reflection, also contribute to a resistance towards depersonalisation. As stated by Gabrielsson and colleagues (2016), depersonalisation can result from 'stress of conscience', reduced personal accomplishment and burnout, which is commonly reported amongst inpatient staff (Maslach et al., 2001). Staff reported a focus on education on BPD, including provision of baseline BPD training to all staff alongside weekly educational sessions where staff are encouraged, for example, to share new research papers or participate in research such as that described presently.

The particular benefit of the ward's use of DBT may be that it provides a therapeutic framework within which staff can operate. A systematic literature review by Dickens and colleagues in 2016 revealed that nurses require a coherent therapeutic framework

implemented as a ‘team-wide approach with nurses as equal partners’ to guide their practice. A study by Hazelton and colleagues (2006) suggests that staff training in DBT alone may also result in a more optimistic understanding and outlook on service users diagnosed with BPD and may lead to an enhanced capacity to engage with service users and promote involvement in their care.

Although universally reported to be collaborative, a barrier to positive practice as suggested by a subset of more senior staff was the care-planning process. This was indicated to be an overly bureaucratic process offering little in the way of meaning for staff or value for service users; Brandon indicated it impedes collaboration. This somewhat aligns with the deeper critique by McKeown and colleagues (2017) that the value placed on current care-planning process is a fiction or “outright delusional,” as it is a mere manifestation of neoliberalism and its over-concern with risk and the façade of its control.

6. Chapter 6 Service User Interviews

6.1 Chapter Overview

This phase of the research investigated experience of care from the perspective of service users on Poppy ward, as described in Chapter 3 Section 3.4.2.1. Beyond contributing to a body of literature relating to service users' experience of treatment, which, while not neglected, is relatively sparse when compared to that of staff perspectives, Poppy represented a unique context in that its management endorses recovery-oriented and person-centred approaches to care. The SUAG assisted in the analysis and interpretation of the research data.

6.2 Methods

6.2.1 Participants and Recruitment

Service users from Poppy ward participated. To introduce myself and become more familiar to service users on Poppy in advance of recruitment proper, I attended a morning ward 'community meeting' which was attended by all service users and staff members on rota.

I then coordinated with the ward manager to identify blocks of time when service users would be available to complete the questionnaires. The ward manager consulted with service users on my behalf to identify convenient times for me to attend the ward and alerted them when I was present. These gatekeepers ensured service users were sufficiently well to participate in the research. There was some degree of ambiguity regarding whether all service users who resided on the ward agreed to participate. Service user participants were compensated for their time with a £10 gift card for Boots.

The transcription process mirrors that described in Section 5.3.4.

6.2.2 Ethical Considerations

Section 3.7 provides an outline of the approach to ethics taken in this research. Here, risks and resolutions specific to service user participants are described.

Because the interviews were conducted with service users in active treatment, there was a perception they may behave unpredictably and possibly pose a risk to either themselves or me. Although this was a rather risk-averse view (Walsh & Boyle, 2009), an early site supervisor advised me to take measures to mitigate possible disputes by the Research Ethics Committee (REC) by ensuring the interviews took place within the ward where immediate assistance could be sought if required, which was complied with.

Another potential ethical risk for participants was that some service users within the recruited ward may not have had the capacity to appreciate what participation in this research involved or its potential consequences. The ward manager was charged with identifying service users who met the criteria of possessing the ability to appreciate risk and the consequences of involvement to make an independent decision about participation, in addition to their ability to communicate this decision. The ward manager was deemed to be in the best position to make this judgment; they were familiar with the concept of capacity, possessed a high degree of knowledge of Poppy ward service users, and therefore had an ostensibly accurate gauge of individual capacity.

6.2.3 Data Analysis

RTA (Braun & Clarke, 2006) was used to analyse the data alongside a critical realist framework; see Section 5.3.5 for a description of the stages involved.

Analysis of this phase of the research was a collaborative undertaking alongside the SUAG. Following Jennings and colleagues' (2018) conceptualisation of the various levels of collaborative data analysis (CDA), the present research undertook a combination of CDA approaches 2 and 4 where approach 2 involves service user involvement when deriving themes from a small sample of data during the early stages of the analytic process; themes which the researcher then applies deductively to the rest of the data. Approach 4 is considered the 'gold standard' of co-produced research where the academic researcher and the service user researchers undertake equal levels of involvement at every stage of the research. In this research, a two-hour long training session on thematic analysis was delivered by me alongside my primary academic supervisor to the SUAG. This was followed by a refresher session as well as provision of ongoing support throughout the following nine analytic discussions. All six transcripts were reviewed by me and the SUAG.

Transcripts were sent to the SUAG at least a week in advance of each meeting. Notes and first impressions of the transcripts were discussed and compared. Over the course of the analysis meetings, the major candidate themes were developed and agreed upon. Following the final analysis meeting, I reviewed the transcript, coding the identified candidate themes and refining the categories, ensuring quotes identified were relevant to each category and combining similar themes. The SUAG was compensated throughout according to the local Trust's remuneration policy. I kept a reflective journal throughout.

6.2.4 Procedures for Assessing the Quality of the Analysis

The approach taken in this phase mirrors that detailed in Section 5.3.6. This phase additionally featured the inclusion of the SUAG in the analysis process. Reflexivity was a key element of the research process.

This research sought to address the research question:

2. What factors do service users believe are involved in the operation of Poppy ward as a positive-practice specialist ward for service users with a diagnosis of personality disorder?

6.2.5 Demographics

Poppy is an all-female ward. Due to the same challenge described in 5.3.2 Participants, the demographics of only three of the six service users interviewed were obtained. Of these, one reported a diagnosis of BPD (22 years old), one BPD and complex PTSD (25 years old), and one BPD and Autism (24 years old).

6.3 Results

In line with the critical realist framework adopted for this research, the results described include input from the SUAG. This decision was made to subject informants' accounts to critical scrutiny in relation to a variety of sources, a stance advanced by Smith and Elger (2012). The four main themes the group developed were (a) shared responsibility and power; (b) everyone takes care of each other; (c) staff are uniquely skilled and experienced and (d) a healthy and helpful place (see Table 6.1).

Table 6.1

Summary of Service User Interview Themes

Theme	Subtheme
Shared Responsibility and Power	Independence Encouraged
	Service User Responsible for Recovery
	Service User Responsible for Safety
	Balance of Empowerment and Assistance
	Service User SDM – Choice in Care
Everyone Takes Care of Each Other	Community
	Relationships Are Warm, Supportive

	Trust
	Human(e) Support
	Service User Reluctance to Talk to Staff
Staff Are Uniquely Skilled and Experienced	Staff Are Good at Communication
	The Importance of Being Direct
	Safety Through Talking
A Healthy and Helpful Place	Ward Structure and Environment Are Helpful
	Ward is a Healthy Environment
	Care-Planning Fitting Its Purpose
	Care-Planning Process Helps Record Progress
	Recovery, Not Risk-Focused
	Staff Attentive, Respond Immediately

6.3.1 Shared Responsibility and Power

Overall, service users felt they were meaningfully involved in care decision-making and were encouraged to take ownership of their wellbeing. This theme is defined by care practices and recovery processes as opposed to interpersonal relationships, which are described in the theme, 'everyone takes care of each other.'

An overall lack of power differential was reported by one service user in relation to power dynamics between service users and staff.

> There's no sort of hierarchy; there's no I'm-up-here, apart from the few odd staff that are a little bit, shall I say, up themselves […] [Laughs] the majority of the staff are very lovely, down-to-earth people and we don't have sort of patient-staff, us-them hierarchy […] We're all people at the end of the day. (Avery)

The absence of a hierarchy was a theme reported by Naldemirci and colleagues (2017) following a person-centred care intervention in Sweden involving researchers, professionals and service users (Naldemirci et al., 2017).

6.3.1.1 Independence Encouraged. Participants indicated their independence was encouraged by staff throughout various aspects of their care. One service user pointed to ward policies that help her to feel safer, namely allowing her the option of locking her door when she wants to. "Um… it's a safe place for everyone… um, I like how we're in control of opening our room or locking them so people-[only] staff can get into them" (Hazel).

The freedom to retain some privacy, particularly given the difficult backgrounds of some service users who may have experienced feeling unsafe in their homes, likely creates trust from the beginning of their admission.

Another service user indicated that she was supported by Poppy ward staff to transition from her section to become a voluntary service user. "When I first came here I was on a section. And it was up to me to decide when I felt ready, um, to be allowed off my section" (Avery).

Although there is some evidence that involuntary attendance on a ward does not entirely impair the possibility of developing therapeutic relationships (Wyder et al., 2015), voluntary admissions likely introduce fewer complicated feelings about the ward experience and towards staff.

Another service user indicated that she was expected to keep track of her own schedule and was held accountable for missing appointments, even if this involved interrupting a ward round, which is a notoriously intimidating process (White & Karim, 2005). She provided an example that had happened earlier on the day of the interview:

> I didn't have DBT-I was meant to have it today, but my ward round overran […] And I completely forgot about my DBT session […] Because my memory's not great at the moment and my DBT therapist said to make sure that next time, I'm aware of the timing of that meeting […] So to make the doctors aware that I've got DBT at this time. (Hazel)

That service users are encouraged, even expected, to self-advocate and effectively challenge staff to follow their care routine was perceived by the SUAG as highly unusual and likely indicative of a structural support for service users to take initiative in their own care. This is echoed in another example of a service user being encouraged to work through a DBT timeline independently, something the SUAG viewed as counter to usual practices, which were thought to entail a great deal of support in reviewing potentially triggering historical events.

> I was asked to do a timeline from when I was born to where I am now and look at the significant events, good and bad, that led me to where I am. I submitted it, but it took me quite a few weeks and it's quite […] Stressful. We haven't gotten to the whole point of talking about it properly, but my therapist is like, now I know exactly where the issues are lying and what we have to work on based on my timeline. (Avery)

While it is unclear whether it was the intention of the therapist to have the service user work on this timeline unsupported, or that she was indeed working exclusively independently, this approach would appear to align with the ward's broader ethos towards encouraging service users to work through their responsibilities independently.

Another service user indicated that she takes notes during her meetings with staff, and that this helps her keep track of her treatment. As noted between myself and my SUAG, this service user appeared to be in charge of the notes she takes in therapy, which runs counter to typical processes. By being in charge of her notetaking, she may effectively have steered her own care more directly.

> I think I do have most of mine [copies of care plans] but also me and my therapist-so a lot of people do, like, paper […] But because I take my laptop to therapy […] Because I find it easier and I find it easier to refer back to […] So I always have a copy […] And normally then email my therapist a copy. (Mia)

6.3.1.2 Service User Responsible for Recovery. Service users indicated they were expected to take ownership of their own recovery and take initiative in creating the conditions for their own growth and mental health journey. Staff were seen to "use the 'tough love' kind of strategy" (Avery) alongside more traditional therapeutic support. As Avery continued to explain, the ward staff's attitude is, "if you can't handle this then, you know, what's the point of being here? […] It's a hard truth that you need to hear sometimes," (Avery). This approach aligns with the DBT orientation, which requires individuals undergoing this type of therapy to agree to particular terms and be active participants in the therapeutic model to be accepted for treatment.

One service user indicated that staff had shared with her they required her to articulate her needs to assist, and that she struggled with that but indicated she understood the impasse:

> But that's my own personal experience. I'm not very vocal about what I want or what I need or even know what I want or what I need. […] So it's been difficult for them to help me. And they've been honest about that, so. (Luna)

Another service user emphasised the capacity to learn to manage her challenges was important for maintaining a sense of normalcy. She described developing the skills so that she can leave the ward and be self-sufficient, having developed the resilience and abilities required to navigate life outside.

> Unfortunately, there is no cure for BPD. But you can learn – as with anything, you can learn to manage your illness to get to a point where you can live a normal life without it interfering, you know. […] So yeah, so this program here focuses heavily on […] giving you the skills that you need to learn to deal with the symptoms of your illness and yeah, basically, giving you that-those skills so that when you leave here, you can, you know, lead a relatively normal life. (Avery)

Skills taught within the ward were felt to be empowering and included both DBT and other life skills.

> We're looking at, you know, I mean, last week we looked at how-what does it take to run a home and life skills, yeah. Um, cooking and yeah, like, lots of different sorts of life skills and activities that enable you to, you know, lead a productive life. (Avery)

As noted in Chapter 5 by a member of staff, many service users admitted to Poppy are reported to come from CAMHS, and likely have not learned to live independently given the persisting paternalistic setup of services (Bladon, 2019). Clearly, key areas of recovery for service users extend beyond mere management of emotional distress and include life skills such as financial management, cooking, and occupational support.

One area described to be of notable difficulty for individuals with a diagnosis of BPD were relationships and their maintenance. One service user described finding the skills taught within the DBT framework relating to interpersonal skills helpful.

> I've learnt some mindfulness skills, some… some interpersonal effectiveness skills, so uh, relationships with people. So, say we've got a difficulty with a member of staff […] To repair that relationship, you use some skills, so just by using these DBT skills, I'd say it's helped. (Hazel)

6.3.1.3 Service User Responsible for Safety. Service users reported being given the burden of responsibility for keeping themselves safe, and that this is involved the collective effort of the ward. For example, as Mia reported: "We're very much learning skills to maintain our own safety, but so is everyone else so there's that sort of environment of, 'we've got to try really hard.'" Another service user (Avery) emphasised that this transfer, while counterintuitive to traditional practice, is ultimately helpful: "So having-having it be sort of more risky sounds like it-it could be risky, but it actually helps."

One service user described an occasion of this transference of responsibility for keeping safe to service users being effective; she described bringing into the ward an instrument with which to self-injure on admission. (Part of Poppy ward's PRT approach includes the elimination of searching procedures.)

> When I first came here I had a blade that I smuggled in from my old ward and I wasn't ready to part with it because I needed a safety net and I kept it in my room for, like, three or four weeks until I decided I should hand it in […] And it was my decision […] To hand it in because I'd realised that as much as I could say to myself, 'oh, I won't use it; it's just there as backup' […] And what would have ended up being quite-potentially quite a serious incident-has been, by my own choice, has been made less risky by me basically saying, 'I have this in my room; can you take it out for me?' […] I've come to the realisation that I need to do this, rather than someone coming in and searching my room, taking it off me […] if I didn't have it in my room, then I wouldn't have learnt that lesson. (Avery).

This approach also speaks to an ownership of risk on the part of the service user, where perhaps on other wards there is an expectation that staff alone keep service users safe:

> It's on your back if you-if I buy razor packets then it's on my-it's up to me to say I've brought something that I was gonna use to harm myself but I don't want it anymore; I want to hand it in, sort of thing […] Um, but when people are self-harming … or doing something, it is the patient's responsibility but they'll just be there to support you to stop and move on. (Avery)

This emphasis on equipping service users with the power to keep themselves safe was expressed by Mia; "you have to learn to talk and do your skills rather than just rely on being stopped [from behaving in a way that leads to restraint]." Service users tended to view the avoidance of direct action on the part of staff in maintaining safety as helpful in the long-term. The use of immediate measures, including more restrictive practices such as coercion or searching service users or their rooms for contraband, were seen as temporary and surface-

level interventions which do not address the underlying reasons behind self-harming or risky behaviours.

One service user described staff's hands-off approach to managing risk as leading to being more proactive, aligning with Levenson's locus of control (1973):

> It's made me realise, […] well, we need to start challenging these behaviours. You know, so the first step would be getting rid of anything in my room that's triggering or that I can use, blah blah blah, do you know what I mean? (Avery)

The SUAG flagged that a service user learning to 'challenge behaviours' was a key message and learning point: that identifying particular behaviours are harmful and taking the actions required to protect oneself appears to be a turning point for service users and their investment in their own safety and recovery.

At odds with the overall view expressed by other participants that being responsible for one's own safety is positive and reduces risky behaviour, one service user reported that this approach has its limits. As Layla indicated, in extreme cases, it would be expected for staff to intervene to maintain a service user's safety; when asked whether she felt safe on the ward, she stated:

> Most of the time. However, I do get urges to do something that … in the past required restraint […] Um, and I feel like if I were to do that and it was taken too far, that I would end up being restrained or not being restrained and put in a situation where … it's a danger to my life" (Layla).

Thus, there was a suggestion that in the event staff fail to employ restraint, this could also lead to a lack of safety. This is perhaps a natural awareness given the nature of risk, the balancing act described with staff providing support from a distance, teaching skills and encouraging their use during moments of distress; but an awareness that in exceptional circumstances, they would likely need to take physical action.

6.3.1.4 Balance of Empowerment and Assistance. A dialectic was identified by service users relating to staff offering support versus empowerment. Service users generally valued the responsibility assigned to them in terms of being independent and directing their own care. However, there remained a desire for staff to take more initiative and action in engaging service users:

> For me personally, I'd fe-I feel better if they just come up to me and ask for a one-to-one […] It would make it easier for them. Ultimately, it is something I need to learn to do, is ask for help. (Layla)

Service users indicated that staff need to strike a balance between offering support and encouraging independence. As expressed by Avery, "But at the same time, that's [relying on staff to approach] not really giving me, um, autonomy either. It's got to be a balance between it-the two."

6.3.1.5 Service User SDM – Choice in Care. Service users overwhelmingly indicated they felt they had meaningful involvement or 'a say' in their care. One definition of SDM offered in the literature by Coulter and Collins (2011) is that it entails a recorded process of clinicians and service users working together to make decisions; the clinician provides evidence-based options and support for decision-making, which allows for a service user to make informed decisions. Service users were not asked specific questions about SDM, only about their experience of being provided choice and having their voices heard in relation to care-planning.

One service user, Hazel, summarised many of the service users' responses when asked about the process of care-planning: "You go to [staff] and sort your care plan out and you're very involved with it." This can be contrasted starkly with existing literature on the topic of SDM in mental health services, particularly acute inpatient services (Slade, 2017).

Some service users indicated they found their active inclusion in care-planning obvious, even unquestionable. Layla indicated she felt her contribution to her care was "pretty equal" and in response to whether she generally felt like she had a say in her care, she answered, "of course, yeah." To the same question, Luna answered, "definitely." Furthermore, service users felt that "Everyone listens and yeah, takes into account how you feel about stuff" (Stella).

Again, service users compared Poppy ward to their level of involvement in other wards or with other services. One service user (Mia) indicated that at Poppy ward "It feels good to be included" and that "in the community you're just kind of getting your care plan. […] You're not really involved in making it, whereas here it's like, always your care, so it's your care plan."

Interestingly, service users made particular note of their influence on decision-making when it came to their medication. SDM on medication was also flagged as a key indication of

true SDM according to the SUAG, possibly given the prescription of medication is exclusively done by psychiatrists who also hold the most power in the traditional inpatient hierarchy by virtue of their typical assignation as role of 'responsible clinician' role (Iqbal et al., 2014; Nugus et al., 2010). Any concession or sharing of power by this party may be seen as particularly notable. The importance for service users to have a measure of control over medication was also noted in Wood and Alsawy's (2016) thematic synthesis of qualitative research investigating service user experiences of inpatient care.

> I recently stopped a medication because I didn't feel it was helpful […] And I'd recently started a new medication and that's more like a joint decision […] And that's not taken away from me or, that I know of, anyone else. (Luna)

While, overall, service users indicated satisfaction with their level of involvement in terms of medication decision-making, one service user reported that she felt less understood regarding medication decision-making.

> Sometimes, in ward rounds […] I'd like to feel more listened to by the doctor, so-he's a very good doctor-but to feel slightly more understood about where I'm coming from […] In terms of …like, medications or what I think I need in terms of therapy […] So I understand that he has his, like, viewpoint from past experiences and education […] But also I know myself quite well and what I need. (Layla)

Despite the general reports that service users were actively involved with their care, there was some indication that this was limited at the procedural stages, for example, the writing up stage. This was not spoken of negatively by service users, however, who largely viewed it as a natural division of roles, with staff being charged with transcribing a care-planning conversation and providing a copy to service users for correction if necessary. According to Layla, "I'd say yeah, we don't-we're not involved in the process of writing it up or necessarily do it word-for-word and how we're going to achieve it."

Another service user (Stella) described the process:

> We just discussed everything and then she, um, put it into my care plan and she showed me a copy and asked me if I'm okay with it… You just check to make sure she hasn't put anything you don't agree with or […] You want to add something. (Stella)

Although this was discussed within the SUAG as a possible example of substandard SDM: that because service users were not described as actively involved in every stage of the

care-planning process, in adhering more to the critical realist approach and 'staying close' to the data, this was not the experience of service users. In fact, to service users, staff notating their conversations with service users and providing their finished notes to service users for correction was perhaps an example of equal role division. However, this approach does relegate service users' roles to that of editors as opposed to co-authors and does expose a risk of their words not being accurately portrayed. An exception to this was the service user mentioned above, who took her own notes by bringing her laptop to meetings with staff.

6.3.2 Everyone Takes Care of Each Other

Service users reported a keen sense of belonging: of being part of a wider social contract to care and be cared for within the ward. Strong relationships, mutual respect, and a sense of obligation to maintain these ties make up this theme, which is overall more relational in nature.

6.3.2.1 Community. Service users described a sense of community within the ward between service users and staff alike: a feeling of being part of a social system with its own internal structure, rules, and unity. One service user, Mia, described the prevention of the use of restraint as motivated by an aversion to cause disruption to the relationships between service users and staff. "I've never known anyone be restrained. Um, I've never known anyone need […] To be restrained […] I think the staff-patient relationship and the pa- relationship between patients. Nobody wants to put each other through that." (Mia)

One service user, Bree, described ward values as "respect, safety and recovery" indicating that respect is essential to maintaining the feeling of community, alongside mutual trust. She went on to state "respect is a big part of that and… it's-it's also protection, but, like, it's very much community […] Um, so looking out for each other, but the staff are also in that community […] And we want to keep that trust and that relationship."

A sense of community extended to a suggestion of friends or family. According to Layla, "It's very friendly. I-I'd go as far as to say family-like. Um, because we live with them twenty-four/seven; we spend so much time with-with them; we play games, we laugh." Avery echoed this, indicating staff "laugh and play and joke with us, play games with us, eat with us, even the doctors." Mia provided further examples of activities that may serve to support this sense of friendly community: "I've found we go on days out on weekends and things."

Service users reported feeling safe approaching staff as well as other service users. According to Hazel, when describing what makes her experience of Poppy positive, "Just how approachable the staff are; the patients are lovely. Even they're approachable. You don't open up and spill your […] [Laughs] all your problems on someone else […] But that's still another patient."

That there are boundaries, whether tacit or explicit, for service users to protect one another, as expressed by Hazel, aligns with the conclusions of Bouchard and colleagues (2010), who investigated peer support amongst hospitalised service users in Canada and found that peer support is a responsive process that involves observing, reflecting, acting, and evaluating outcomes. This was supported by another service user, Avery, who described being aware of each other's vulnerabilities:

> We have no-no talk about self-harm and no talk about or showing any wounds or healing wounds, dressings, anything like that. Um, we know that we very easily trigger each other. So we're very mindful about how we are around each other […] And because we're also from similar symptoms and the same kind of illness that we both-we all know instinctively what's triggering and what's not […] It's handled with [pause] like, care. (Avery)

This sense of community is perhaps maintained by more informal, non-treatment-related activities organised by the ward, which perhaps create a sense of informality at the same time as facilitating bonding. Group activities were mentioned by several service users as part of their description of the ward as well as the relationships they had with others on the ward. For example, Avery stated: "Having the support there is great also with that, laugh and play and joke with us, play games with us, eat with us, even the doctors." Mia went on to describe:

> I've found we go on days out on weekends and things, so yeah… Um, the relationships we build with other patients here are very different to any hospital because we do a lot together; we're a community. We cook together. (Mia)

The emphasis on informal bonding activities may be related to the value service users place on feeling 'normal', and perhaps letting go of their role as 'patient' during these activities.

6.3.2.2 Relationships are Warm, Supportive. Service users described relationships, particularly with staff, as warm and supportive. One service user (Stella) described overall good quality relationships with ward staff, feeling comfortable to approach them when needed. "Um, yeah, [relationships with staff are] really good […] Yeah, they're very approachable and they're kind of always there, so if you're having a moment then you know that you can go and speak to them, stuff like that" (Stella).

One participant, Layla, described the relationship between service users and staff on the ward as being "very friendly. I-I'd go as far as to say family-like. Um, because we live with them twenty-four/seven; we spend so much time with-with them; we play games, we laugh."

Other service users described their relationships with all staff as good, but with particular closeness with a subset of staff, who they feel they "have better relationships with. Um, more just personalities that click." (Mia)

> But even the fact that I don't have that, like, intense relationship with …it's still very good, like, genuinely, like, generally that's supporting […] However, there are certain members of staff I do lean towards […] Um, just our relationship's a bit stronger. (Luna)

One service user (Mia) described the general positive regard reported by most service users as being explained by respect. She described how bank staff, who were described anecdotally by the SUAG as being undertrained and prone to restrictive practice, as being part of this mutual respect: "They know [how to interact with service users with a diagnosis of BPD] mostly off their own back… so it, yeah, provides a safe-feeling environment, um… the respect for each other, I think."

There were exceptions to the overall feeling of genuine, good relationships among all stakeholders. One service user described feeling alienated by the MDT.

> I think because I'm quite quiet, I kind of get pushed to one side a little bit because I'm not at the forefront of every, um, handover, every meeting or anything like that. It's kind of from the get-go gave me a bit of distance between me and, like, the MDT. (Luna)

6.3.2.3 Trust. Beyond 'clicking' with particular staff members, trust was seen as an integral ingredient for service users in feeling taken care of and taking care of others. Trust may seem antithetical in the context of inpatient services, which are often criticised for involuntary admission (sectioning); however, perhaps trust is possible in Poppy ward due in part to Poppy's avoidance of involuntary admissions and its focus on fostering a sense of community.

As Luna stated, the staff she is able to trust are able to meet her needs more effectively.

> I'm very funny about who I speak to. Like, I have to feel I know I can trust- that I've built a relationship with-I can't go straight into the conversation and talk-like it takes a while to figure out and that kind of stuff […] But the people who I do trust and I do talk to … manage me very well and know … what-like, how to support me. (Luna)

Service users indicated they were motivated to avoid breaking the trust built with staff, and they viewed staff as being similarly motivated. For example, as Mia stated "I think we have quite good relationships with staff. There's kind of mutual trust a lot of the time. Um, and not wanting to break that trust."

Another service user indicated that trust is not an immediate process: that building trust takes time and at the point of the interview, she had not yet begun to feel comfortable in being vulnerable with staff.

> It's just my tendency-I'm not used to being vulnerable around people; I'm just used to putting on a front. It's my-it's not a reflection on the ward. It's just that I myself personally find it difficult. But when I do get to know the people better, it will be easier because they are very open here and understanding as well. (Avery)

6.3.2.4 Human(e) Support. Service users indicated feeling that staff are present and there for them. This was demonstrated by staff making the time to be with them. As stated by Mia,

> We always have an allocated one-to-one each shift and, um, they will always make time to speak to you if you need them. Um, the staff also come on set hours after lunch instead of sitting in the office, which helps to, like, build relationships. (Mia)

Staff were commended for being present and making themselves available to talk to service users. “But there’s again, a lot more sort of caring and, like, they take to time to speak to people” (Stella).

Another service user described feeling supported by staff’s presence and reassured that she knows they would be available to listen if she needed them. “I know that although I don’t speak to them very often, but it’s comforting to know that they are here and I know that they would listen if I had something to say” (Luna).

Staff were also described as being perceptive of service users’ moods, personalities, and knowing when to offer support. Stella provided an example: “they notice when you’re not necessarily yours-acting yourself […] So they’ll say, ‘do you want a chat?’ […] Stuff like that is really helpful.”

Service users felt that staff are understanding and supportive: when asked whether she felt understood by staff when talking to them about her challenges, one service user indicated that she did; when asked if this could be enhanced in any way, she said no, staff are already “really good” (Stella). Stella indicated the reason she feels safe on the ward is the presence of staff support: “It just seems to work having that support there. Yeah, it just seems to work.”

Another service user gave an example of a time when staff supported her to communicate her needs more effectively, coming up with an individually tailored solution that supported her to maintain independence.

> What I found helpful the other day was writing down what I was feeling and then they encouraged me to talk about it instead of them reading it […] It just gave me a reminder of what to say […] Not necessarily looking at it, but just having it there and sort of like a comfort blanket in a way. (Hazel)

Staff were often described as approachable, as stated by Stella, “They’re very approachable and they’re kind of always there, so if you’re having a moment then you know that you can go and speak to them, stuff like that.” Avery provides further detail:

> The majority of the staff are very lovely, down-to-earth people and we don’t have sort of patient-staff, us-them hierarchy […] I’m still getting to know them all. So there are people that I got good vibes off straight away that I know I can speak to and there are certain staff that I’m not sure of but that’s probably just, you know. But they are-most of them are approachable I get on well with them. (Avery)

6.3.2.5 Service User Reluctance to Talk to Staff. Despite staff approachableness and service users generally feeling supported within the ward community, service users reported finding it difficult to speak to staff due to internal invalidation of their feelings or not wanting to burden staff with their emotions.

> I feel like nothing on their [staff's] part; it's me. They're very much very open and willing to speak to me. It's my not wanting to bother people […] Or, oh, I'm just being dramatic. Um, but no, I am working on it-to speak to people more regularly. (Layla)

For other service users the motivation to protect oneself through isolation or 'putting on a front' led to a reluctance to speak to staff.

> It's just my tendency-I'm not used to being vulnerable around people; I'm just used to putting on a front. It's my-it's not a reflection on the ward. It's just that I myself personally find it difficult. But when I do get to know the people better, it will be easier because they are very open here and understanding as well. (Avery)

Avery went on to explain that her reluctance to be vulnerable with staff stems from previous unhelpful responses she had received in other services. She described a process of unlearning to anticipate negative responses from staff and services. For example, negative or even damaging responses to self-injury have been noted in the literature (Johnstone, 1997).

> I literally have come from [English northern city] and everything's new. Everyone was new; I don't-so obviously it's taken me a little while to get to know people; plus I've got my own issues about getting to know people and that. Because I'm, like I mentioned before, there's a lot of stigma-I've faced a lot of stigma […] When I've been in places like A&E and things. […] I still have that expectation, uh, like, that I'm gonna get that hostile response because it's just, like, a learned response.' (Avery)

As alluded to by Avery, there was a suggestion that reluctance to speak to staff could be experienced at an earlier stage of treatment, although other research has concluded service users need to be approached for communication to take place (Gilburt et al., 2008). One service user (Hazel) described being on the ward for "five to six weeks" and having experienced difficulty adjusting. She spoke of a conversation she had with a senior member of staff, who reassured her this was a typical experience at her stage of the treatment process: "[They] said to me that you usually come here-you have a good couple weeks, then a bad few weeks, then you come out of that and you're-you're settled."

Staff were seen as being willing to relate humanely to service users' distress, whether this was with kind words, or by reassuring touch. This was seen to nullify any need for coercion.

> I know that people are very good at verbally, like, de-escalation. They're talking to people rather than straight panicking and putting hands on. I've not seen it happen here. Um, I know that when I've been very distressed, their approach has been more to, like, comfort me and like, put a hand on my shoulder oar […] Like, put their arm around me as a way of saying, like, you're okay but also just being there. (Luna)

Another service user described an example of a time when her behaviour would likely have resulted in the use of restraint in other wards or contexts. Instead, staff chose to sit with her and see her through her emotional distress.

> There was a time when I was having a flashback and I was hitting my head against a wall […] And they could've restrained me away but they spoke to me and sat with me and helped me, like, focus on… on them being present. I don't think that would've happened-or my experience is that it hasn't happened in other wards. […] Um… the focus is very much on… you getting through it. […] Rather than you being stopped as quickly as possible and at any cost. (Mia)

This service user indicated that compassion and patience tend to more effectively address the root causes of distress that would otherwise lead to restraint. She went on to state:

> I think a lot of the time restraining someone doesn't make them want to stop [risky behaviour] […] It just forces them to stop those conversations [pause] you can express yourself, you can figure out a better way to deal with it. And saying you probably don't want to do it anymore. Whereas my experience of being restrained and then as soon as you're not restrained you still want to, so you engage in it again […] And then you get restrained again […] And it gets into a cycle […] Whereas here that cycle's not even started because the staff listen and give you time. (Mia)

Service users acknowledged their relationships with staff are occasionally tested by disagreements or misunderstandings. However, disagreements tend to be worked through and discussed. One service user related her experience of establishing how to communicate with staff, emphasising that while imperfect, they have come to an understanding and a common ground:

> When I first got here I would be just crying a lot and staff would be like, 'what's wrong?' and I'd be like, 'I don't know, I don't want to talk about it' […] Like, trying to figure out my emotions and try to voice it is very difficult because I do also have a

> diagnosis of autism … so it took them a while to figure out that I did want to talk, I just didn't know how to phrase it […] yeah, I think it took them some time. And even now [pause] they can sometimes get it a bit wrong and I sometimes get it a bit wrong, but we're at a point now that we can talk about it. (Luna)

Another service user gave an example of having a disagreement with a member of staff, which resulted in the staff member re-examining her position and making a change to better support the service user.

> There was another time where I had a disagreement with [a member of staff] um, because she wasn't listening to be about my, uh, genetic condition […] Um, so I said I wouldn't see her anymore. But she read a book about my condition, like an A-Z guide in, like, a weekend […] So I said I would give her a second chance and it's-it's gone really well since then; she's got more understanding about it. (Mia)

6.3.3 Staff are Uniquely Skilled and Experienced

The SUAG was particularly sensitive to service users discussing the importance and value of staff knowledge of BPD and how this competence made the experience on Poppy ward different to experiences on other wards. As stated by Avery, "The staff […] are very familiar with the symptoms and the behaviours associated with BPD, which I think is the most important thing."

Service users' emphasis on the necessity of specialist understanding can perhaps be contextualised with a comparison of non-specialist services, where research indicates prevailing attitudes remain negative towards those with diagnoses of BPD. This complements the discussion earlier around unhelpful attitudes towards self-harming behaviour in other services, including A&E and in acute wards, as Avery further explained.

> If I were to harm myself on an acute ward, I would get a mixed reaction […] One person might understand, one person might be very, you know, critical or very angry, feeling like they've been manipulated because I've managed to smuggle a sharp in. […] One of the things I saw in an acute setting is if I was in a distressed situation or if I needed to talk and I wanted to, like come to the side here and talk, I would get into a conversation that might be quite distressing-triggering, for example. (Avery)

Layla described how staff with an understanding of the BPD diagnosis tend to be more compassionate given their knowledge of the origins of BPD and its manifestations in behaviour: "It's very-the specialised aspect of it is really good because [staff] understand

where you're coming from and other PD patients, where other wards discriminate to an extent."

An exception to staff being understanding of BPD was described, however, by Hazel, who indicated, "There was a problem with a bank member of staff the other night […] I think their understanding… of personality disorder may not be that great […] So they restrained a little bit, I think."

This was the first allusion to restraint having occurred on the ward. Being one of the last interviews conducted, this may have been the first incident for some time. The service user had not witnessed the incident and so no further questions were asked; however, the allusion to bank staff being more prone to using restraint resonated with the SUAG, who were aware of similar scenarios occurring on wards in the local Trust, typically occurring at night when bank staff more frequently are on shift.

Service users also described finding staff knowledge of DBT valuable, particularly in an advisory capacity. As stated by Mia:

> The staff all know the DBT stuff that we're trying to use. So if you need support, they know what they're talking about." Hazel expressed similar sentiments: "[Staff are] very good at advising you to use your DBT skills that you learn in DBT sessions or distraction techniques. (Mia)

6.3.3.1 Staff are Good at Communication. Communication has been described to be essential for a positive experience of treatment in the literature, both for staff and service users (Wilson et al., 2018), despite the reluctance to speak to staff explored earlier. Being open and honest was described as important for staff in the interviews described in Chapter 5; it appears just as important for service users on this ward.

6.3.3.1.1 It's Good to Talk. Service users described the high quality of communication with staff. As Layla said, "We, you know, have good chats." Talking was reported to be encouraged regardless of the topic. "[Staff] say we should use [one on one time] even if we don't have much to say, just 'cause it's good to talk" (Stella).

Meaningful communication was described by service users as being instrumental to navigating difficulties in conveying particular challenges, and for staff to collaborate with service users to provide effective support. Service users did indicate the combination of skill and speaking to service users is important and valued more than just talking alone. For

example, as Layla stated: “I find it quite in terms-they actually use skills-they’ll tell you, oh, to use this skill or that. Um, rather than just speak to you.”

6.3.3.2 The Importance of Being Direct. As suggested by Luna, service users emphasised the importance of being direct with staff when communicating their needs. Luna went on to describe the times she felt her preferences were not observed were when she did not state them directly for staff.

> Researcher: “Have there been times when you feel like you wanted something and that didn’t happen or?”
> Luna: “Uh, no, I think that only happens because I don’t ask directly […] So staff probably don’t know that I want something […] And staff feel comfortable to ask me directly and be honest with me because they know that works.”

Similarly, another service user emphasised ‘straight talking’ with staff as ultimately benefitting service users’ treatment. This is an important departure from the attitudes expressed by service users in other services (Jones & Crossley, 2008), where internal shame and stigma may deter complete openness, or external cues may further reinforce a less open approach.

> It’s really important that staff know what they’re dealing with and the behaviours they’re dealing with and why. And that is a way, then, that, you know, we can talk openly about it rather than it being all secret hush-hush. (Avery)

Although service users described the importance for them to be direct in communicating with staff, one service user indicated the same standard is not adhered to by staff, feeling as though staff shy away from identifying their practices, or the goals of some of the care-related conversations they have with service users. This resulted in some frustration for Luna:

> I feel like you never have that conversation either, where it’s clear about what you’re talking about and what the goal is of the conversation or anything like that […] You’re just talking […] I think staff will kind of go around things in a weird way and like [pause] kind of beat around the bush […] I’d rather they’d just be honest, like this is what we’re doing. (Luna)

This service user took similar issue with practices being spoken about instead of notated or recorded. She found the absence of recorded conversations limiting in terms of

everyone 'singing off the same hymn sheet' as addressed elsewhere in the literature (Pisciotta et al., 2019).

> [The] biggest problem here is that everything is just kind of spoken about […] I think if-in that case, right now we're doing this; we're working just on this […] And if it was written down and stuff like that it would be easier […] And so it can be a bit confusing and we and staff aren't always on the, like same page […] Or know the same information. (Luna)

6.3.3.3 Safety Through Talking. When discussing how staff helped keep them safe from the escalating distress that might otherwise lead to the use of restraint, service users cited staff talking to them and other service users to de-escalate the situation.

> There isn't really any restraint, to be honest. You know, if, um, something's happening or someone's distressed, generally speaking, you know. Staff will approach them, talk to them, take them to the side room and talk about what's upsetting them and give them a chance to air it. (Avery)

6.3.4 A Healthy and Helpful Place

6.3.4.1 Ward Structure and Environment are Helpful. Service users spoke about how the inpatient experience in the Poppy ward is one of safety; how its services assist them to build skills to manage their daily lives; that everyday practices are useful and promote recovery; and how the ward is a good place to be.

6.3.4.2 Ward is a Healthy Environment. The ward was spoken about in terms of being a healthy environment. As Hazel indicated, "the ward is kept really tidy and […] the cleaners are very good at [keeping it clean] … spotless […] Yeah…. Um, yeah, it's just a healthy place to be in." Although Hazel did refer to the physical environment of the ward, the shallowness of her description aligns with Rose (2018), who indicated that although these are often mentioned as important in the literature, this would seem to be because "clinical researchers believe this to be important" (p. 768).

Another service user indicated that Poppy ward's structured programming is a stark contrast to previous experiences of services and how beneficial this is for her motivation to take better care of her health:

> In-on my old ward, there weren't any activities that we needed to do, so when I was, like, seriously physically unwell from my self-harming, it didn't matter that I'd spent

> all day in bed but here, we have to be up, we have to be dressed; we've got a community meeting, a walk, and it's making me realise the-the actual damage that I'm doing to physiological body. […] it's making me realise that these behaviours are actually having a-you know, affecting day-to-day living. (Avery)

Service users described a full schedule of activities; this was supported by my experience as it was difficult to schedule the service user interviews due to the busy schedule on the ward, with service users attending psychoeducational and therapeutic appointments throughout the week. "[W]e have a busy timetable with Monday to Friday of groups that help our recovery and we do DBT therapy as a group and have individual DBT therapy" (Mia). Avery indicated that while there is structure day-to-day, this is not experienced as rigid:

> I mean, the group attendance is expected to stay above seventy percent, um, and obviously we are reminded of the core values and that of the ward and, you know, about bringing contraband on and things like that, but yeah we do. […] Generally speaking, we have a lot of flexibility. (Avery)

6.3.4.3 Care-Planning Fitting its Purpose. Service users overwhelmingly reported finding the care-planning process on Poppy ward beneficial and a positive experience.

Service users were largely satisfied with the care-planning practices on Poppy ward, describing very little they would change about the process. According to Stella, "to be honest, I've kind of agreed with everything they've said so far […] I've not really had any issues."

Another service user (Layla) reported the care-planning process helps to create hope for the future: "The process is very good in terms that they talk you through it; you sit down. It always gives you hope that being here's going to work."

Care planning was also described as a flexible process. One service user indicated staff are flexible in the support they provide and they "make it quite… easy to do" (Mia), adding "I guess they don't make it complicated or sort of leave you to it; they support you as much or as little as you want with it." Care plans were described as easy to change, as described by Layla.

> It's quite easy to bring up in communal meetings […] make-scribble on any notes that I want to change or ways that things are worded that I don't like […] And then I get a fresh copy. The only bits that she can't change are, like, entrances [sic] from the physio or from [the consultant psychiatrist]. (Layla)

Service users indicated the staff member who assists them to work on their care-plan is also flexible: "anyone, realistically, could help you with that [changing a care-plan]" (Layla).

Service users described the timing of care-planning as flexible as well: it can be rescheduled to accommodate events that come up. As explained by Layla, "Sometimes [care-planning is] missed for whatever reason […] Um, or we can do it whenever we need it, so if something drastic has changed, for example."

A need for flexibility was described in terms of the timing of completing a care-plan. One service user described her mood as determining her emotional capacity to care-plan, "Definitely I find it difficult to look into the future when I'm feeling down." (Layla)

Another service user indicated the flexibility in care-planning is fluid and there are areas where requests to change care-plans aren't always allowed, but that staff will provide a rationale for this. "If I want to make changes, um, then generally they're more than welcome. And if they are challenged, they'll be challenged for a-a valid reason" (Avery).

Avery indicated that her primary nurse allowed for more flexibility in terms of timing: that given she was newly accepted onto the ward, this could be updated as needed.

> Well, I met with my primary nurse. Um, I think the first week of admission and we had a catch up a few-a week or two ago and just mentioned we worked through a care plan, noted any changes. Because I'm still new here and there's not a lot-apart from the changes of my medication, there's not really a lot of changes involved in my care plan at the moment. (Avery)

There was a suggestion there is inflexibility in care-planning when service users first arrive which was experienced as unhelpful.

> I didn't really know what to say because we did [the care plan] pretty straight after I got here and I remember just, like, pretty much lying on it. So, she would be like, 'what do you want to be after you go to college?' […] I don't really want to go to college, I just said it because I feel like I should have that in the care plan. (Luna)

Care plans were described as subject to regular review and revision as part of normal ward protocol. For example, according to Layla, "It's regularly updated and […] Um, it is monthly" and according to Mia, amendments also occur as a consequence of new knowledge, such as an occasion when she observed another service user collapse: "Like, they collapsed and my friend collapsed and I didn't realise it was a trigger. So we added it in" (Mia).

Luna, however, described not having experienced regular updates of her care plan and her frustration at this failure.

> I've only really done care-planning once since being here […] There's only been one time where I've sat down. Like, key nurse talked about what's going in the care plan […] So there's been no, like, structured … like, every month we don't review it; it was just that one time […] It would be better if it was more, like, updated. (Luna)

6.3.4.4 Care-Planning Process Helps Record Progress. Care-planning was felt to be a helpful record of therapeutic progress for some service users, and a way to reorient themselves with their treatment goals. This seemingly had a practical utility in checking on goals set; as Mia indicated, she referred to her care plan "mostly to sort of align myself with my goals, check what I need to be working on." Layla also seemed to use her care-plan as a meter of her progress: "It's very useful; I've already achieved one of my big goals on there […] Since being here. Um, supported by staff and occupational health therapists. Um, so it seems to be working [laughs]."

Mia went on to say that it is inspiring to look back at previous copies of her care plans to check in with her progress and reaffirm how far she has come, being:

> A very different person to the person that arrived last December […] Um, and my care plan-if you look at them over time, they reflect that […] Um, so I find it quite an encouraging process to see my sort of progress. (Mia)

6.3.4.5 Recovery, not Risk-Focused. Service users described Poppy ward as being recovery-focused, most often comparing this approach to other ward or service experiences they had had in the past. One service user indicated that compared to acute inpatient wards, Poppy ward focuses on enabling recovery which requires a particular mindset in order for the programme to be effective.

> It seems completely different to anything I've ever been on. Um, I'm usually on acute wards, which involves me being quite unwell. However, being on this ward, it's very much recovery-based and you have to be in a certain mindset to be here to work. (Layla)

Avery elucidated her views of what recovery looks like for her, and how Poppy ward supported her with this. Similar to research on personal recovery, recovery for her is living a 'normal' life, including working and living independently.

> But you can learn – as with anything, you can learn to manage your illness to get to a point where you can live a normal life without it interfering, you know. […] Do all those sort of basic kind of life things that people who are well sort of take for granted. (Avery)

Given the various interpretations of 'recovery' possible, Layla went on to specify how the ward supports her recovery compared to other wards, which is by supporting her to plan for her future.

> It's been an ongoing thing, so I've been in mental health services for a while […] So [the care plan has] just been developed over time. Um, however when I come here, it's become more … recovery-based rather than […] Um, I'm feeling … like I want to self-harm, do X, Y, Z […] It's more, I would like to do this in the future. (Layla)

Some service users tended to pit recovery against risk in terms of the overall orientation of a ward. Avery argued that Poppy ward is different from other wards because, in her experience, other inpatient wards in her experience are hyper focused on risk, which she believes is not an effective long-term approach given that it does not address the root cause of risky behaviour.

> I came to [Poppy ward] at the end of August, and from an acute mental health ward. Um, the ward is designed and this program is designed to have a different approach to the way borderline personality disorder is treated. Um, because in acute wards, you're simply managed by your risk and once you are no longer a risk to yourself or others, or generally speaking, most people with BPD turn their anger in on themselves. Then you are discharged back into the community, but you are not, you know, in an acute ward setting and it's good when you are in crisis, but you know, you're not in crisis every day and so the place set up for you puts you skills that you need to live with your illness. (Avery)

Interestingly, this service user seemed to contradict herself, saying Poppy ward does focus on risk; however, the implication seemed to be that service users themselves would learn to manage their own risks through the development of skills to live their lives more independently.

> So yeah, so this program here focuses heavily on management of risks and the-giving you the skills that you need to learn to deal with the symptoms of your illness and yeah, basically, giving you that-those skills so that when you leave here, you can, you know, lead a relatively normal life. (Avery)

The recovery orientation seems to manifest in the ward's approach to restraint. Service users indicated the default position of ward staff is not to restrain. Luna expressed doubts about ward staff's preparedness to restrain even in extreme circumstances.

> Luna: Um, so I think [this ward] just doesn't really like restraint.
> Researcher: […] Maybe it's just kind of not even not thinking about it as an option.
> Luna: I don't think [staff] do. I don't think-I don't know if they'll be able to manage it […] I think they'd panic and be like, what-what do we do?

Layla found this reassuring, although perhaps equally reassuring that it might be done as a last resort, contrasting with the anxiety she conveyed earlier relating to her safety as a result of being restrained or not restrained in the context of responsibility for one's own safety.

> Um, I find restraint quite traumatic from the past. Um, however, restraint on this ward isn't a thing. […] I've never seen it, I've never heard of it. Um, but I assume in extreme cases where it's necessary, it will be enforced […] Because ultimately, it is the patient's safety. (Layla)

Avery echoed that in extreme circumstances, restraint may be used by Poppy staff; however, this seemed an unlikely event.

> Well, we already know coming in that [Poppy does not use restraint] and I think that if it-I think that if the situation arose, you know, then that would happen and, but like I said because of the DBT and the group skills that we're learning, we're learning different ways. So like, I haven't seen a restraint happen here. (Avery)

This also perhaps supports the development of epistemic trust, or trust in the authenticity or accuracy of information transmitted by another individual (Fonagy & Allison, 2014).

6.3.4.6 Staff Attentive, Respond Immediately. Staff were seen to take service user experiences of treatment seriously in terms of ward-wide suggestions for change. Layla gave an example of food being stolen and staff's immediate action to address it: "So someone has been taking [food]. Um, however, I suggested that we get labels for food, which staff implemented straight away."

This service user went on to note, however, that despite repeated conversations with staff around preferring advance notice when new service users are admitted onto the ward

and agreement to address this, communicating to service this particular change to service users continues to be neglected.

> When we get new patients, uh, we get them with no warning whatsoever […] And it has been brought up a few times, that we want some … notice […] It is a big change and we'd like to prepare ourselves […] Rather than the day before […] they said they'd do it, but I think it's just- […] Yeah. They're not doing it [laughs]. (Layla)

6.4 Discussion

This research offers insight into the perspective of service users within a specialist service for individuals with a diagnosis of personality disorder; results present evidence that SDM, PRT and the provision of all staff with specialist training on the diagnosis of personality disorder are possible in this context and are experienced positively by service users.

The four themes represent closely related but nevertheless distinct aspects of Poppy. 'Shared responsibility and power' represents Poppy's egalitarian processual and orienting position while 'everyone takes care of each other' represents relational dynamics. 'Staff are uniquely skilled and experienced' describes service user perceptions of staff competence and understanding while 'a healthy and helpful place' encompasses the structure and every day running of the ward. Of the four themes, 'shared responsibility and power' and 'everyone takes care of each other' are possibly the most closely linked given that interpersonal interactions between staff and service users are necessary to enact Poppy's egalitarian philosophy.

There was some overlap between the findings from staff interviews in Chapter 5 and the service user interviews reported here. Both staff and service users reported valuing staff specialist knowledge and skills and empowerment of service users through shared responsibility. An important theme shared by both staff and service users was an emphasis on relationships. Reflecting staff interview findings, service users emphasised the importance of relationships for positive experiences of care, encapsulated by the theme 'everyone takes care of each other.' Both relationships and a sense of community on the ward were reported in service user interviews, mirroring staff findings. Service users describing their relationships with staff and other services users as warm and friendly, even family-like can perhaps be traced back to the deliberate non-clinical time spent together, staff and service users alike. Service users describe staff taking part in games, cooking and eating together, and going on weekend trips away. Although activities have been described elsewhere as an intervention to

address boredom (Foye et al., 2019), activities in which staff and service users participate together as informal relationship building was not found commonly in existing literature.

Another finding of note related to peer-to-peer relationships between service users on Poppy ward. Although these relationships were not described at great depth, there was a focus on mutual respect and being mindful of one another. This was interpreted in this analysis of observing boundaries with one another. Whether these rules were tacit or explicit, service users, particularly Avery, indicated this was also a show of respect for one another.

Service users putting particular emphasis on their relationships with staff and rating them resonates with relational-cultural theory, which describes the particular importance of relationships for women specifically (Miller, 1976). Larsson and colleagues (2016), in a study on the impact of mentorship for young women in Sweden, explained that women learn, grow, and develop meaning through relationships with emotional bonds (Jordan, 2001; Larsson et al., 2016). In another study comparing the experiences of men and women, Schön (2013) found that women tend to highlight the necessity of trusting relationships with staff as well as emotional support. Although not addressed in the interviews, there is a possibility the supportive and positive relationships developed between service users and staff was the mechanism that facilitates the learning of DBT skills as well as the impact of the treatment as a whole. Another area that has been flagged as relevant in women's treatment in psychiatric inpatient services is the role of attachment theory and the evidence that women with insecure attachments styles on inpatient wards experience higher rates of difficulty emotionally and relationally bonding with staff (Archer et al., 2016; Hietanen & Punamäki, 2006).

It is worth addressing Avery's claim there is no hierarchy between staff and service users. While this is a positive perception of the dynamics on the ward and implies a highly creditable effort on the part of ward staff to cede power in their everyday interactions, it is undeniable that power dynamics are embedded within the structure and operation of inpatient wards. Even on Poppy ward, where involuntary admissions are avoided, staff nevertheless grant service users permission to enter and leave the ward; have veto power regarding treatment decisions; and can exert legal power. However, given that this is the way the current system operates and is likely to remain this way for the foreseeable future, the minimisation of perceived power differential aligns with one of the organisational challenges for services to become more recovery-oriented as described by the Sainsbury Centre for Mental Health (Shepherd et al., 2010).

One practice identified by service users as being satisfactorily implemented is SDM. This is an important finding given that in 2014, the NHS Community Mental Health Survey

in England concluded that only approximately 50% of service users would agree with statements pertaining to satisfaction with their own involvement in their care. All the participants in this study reported satisfaction with their level of involvement in their care. This was particularly true in relation to decisions related to medication. That service users specifically emphasised feeling supported to make decisions around medication is not a common experience in the literature given its categorisation as constituting 'controversial decisions' (Hamann & Heres, 2014), and this is echoed by the SUAG's feedback. Service users' general perception of shared power or control over medication decision-making may be taken as an indication of Poppy ward's genuine application of SDM principles. Only one service user, Layla, indicated dissatisfaction with her level of input in ward rounds. While this suggests the manifestation of epistemic injustice often referenced in SDM literature, it is unexpected that this was not mentioned more frequently in the context of inpatient services given the ubiquity of power differentials within mental health settings and the need for expediency in decision-making. Equally, service users' description of PRT practices can be contrasted to recent findings by Coffey and colleagues (2016), who found that while service users value risk-taking, they feel the risk assessment process would lead to loss of liberty and that a collaborative orientation does not extend to risk management practices. Findings from Poppy service user interviews indicate this experience is not universal.

Another unexpected finding was the satisfaction of service users with the care-planning process. Previous research (Coffey et al., 2019) indicates that service users are largely underserved by the typical care-planning process, particularly relating to their active involvement with care-planning. Service users in this study reported inclusion in the development of their care planning up to the point of its transcription, which was almost invariably left to staff to complete. Service users did not indicate any dissatisfaction with this process, although one service user, Mia, preferred to take her laptop to sessions, indicating that it allowed her to refer to her notes, and Luna expressed this was something she also would have preferred. Wood and Alsawy (2016) found that service user involvement in care-planning can, for some, mean a 'double-edged sword' in that service users may feel they are under additional pressure to make the 'right' decision, which may feel doubly difficult when already struggling. This finding was not represented in this study, although timing was cited as determining the helpfulness of care plans.

Service users often referred to the ward structure itself being safe and structured, comparing this to other wards or services they had experienced. There was a sense of Poppy ward providing sanctuary. Although the yearlong DBT design of Poppy ward is not as easily

duplicated in other services considering the resources involved in supporting it, what seemed to be the main benefit was the support for service users to feel secure and safe; to feel a sense of routine and structure but also to know that staff subscribed to a recovery focus. As Shepherd and colleagues (2010) argue, recovery-promoting practices focus on "changing the *ways* in which things are done, rather than on an injection of new resources," (emphasis in original; p. 4). This focus on recovery over risk (PRT) is noteworthy given the context of the ward and its specialist remit. Services tailored to service users with a diagnosis of BPD tend to focus on risk by virtue of the self-harm behaviours common in individuals with this diagnosis; thus, retaining a recovery orientation amidst what are certainly strong pressures from higher power structures is commendable.

An unexpected finding discussed amongst the SUAG and me was the prevention of restraint was enabled by various factors across themes which combined synergistically to enhance safety, emotional management, relational skills, and relationship quality, while decreasing conflict, boredom, a sense of hierarchical divide, and frustration over arbitrary or conflicting ward rules applied without consideration for circumstance or nuance. In the literature, coercion or restraint are typically targeted by interventions seeking to reduce their use; staff training and particular techniques such as de-escalation are described (D'Orio et al., 2004). That restraint was referred to as a remote possibility seems to support a more cultural or ubiquitously recovery-oriented milieu which serves to deter manifestation of coercive intent. There being a vague reference of an incident is still some cause for concern, and the association with bank staff supports certain issues brought up in the CQC's 2017/2018 report (CQC, 2018) regarding the state of health care in England. Budget cuts have reportedly resulted in hiring more temporary staff which, some have argued, has created a false economy, as more costly emergencies may be the ultimate result. Unlikely to benefit from de-escalation training or an understanding of service user distress, bank staff likely suffer an emotional toll because of these encounters; there is some evidence to this effect (Jenkins & Elliott, 2004).

7. Chapter 7 Psychological Formulation Literature Review, Model Development and Model Training

7.1 Chapter Overview

The following chapter begins with a justification of the need to develop a model of psychological formulation to address the gaps identified in the previous chapters' findings. This is followed by a discussion of what makes a 'good' formulation, which includes a critical review of the 'validity' debate. A review of the common formulation modalities used in the NHS is followed by an exploration of collaboration in the development of formulation. A critique of existing models of formulation is then provided, which precedes the identification of gaps in existing formulation models.

This chapter then details the rationale for the development of the PNM; discusses the philosophical foundations of the PNM as well as its alignment with critical realism; describes which and how published theories and models of formulation were adapted and incorporated in the PNM; and provides details related to the SUAG's involvement and the iterations of the PNM. An exploration of the most recent iteration of the PNM is provided.

This chapter concludes with a description of the development of the PNM training sessions delivered to Poppy ward staff and includes the theoretical rationale for design decisions. The training itinerary is provided alongside a description of the training delivery itself, including attendance rates. The chapter concludes with a description and discussion of the challenges encountered.

7.2 Psychological Formulation as a Bridge over Streams

This chapter addresses the third research question:

3. What does a model of psychological formulation, collaboratively developed alongside local stakeholders to address their needs, look like?

As described in Chapter 2, psychological formulation has been identified as a possible support for positive practice. Research has indicated, for example, that formulation can support recovery-aligned practices (Blee, 2015; Evans, 2020) as well as SDM (Blee, 2015), and PRT (Clarke, 2015; Lewis-Morton et al., 2017). Psychological formulation may also indirectly reduce the use of coercive practices by supporting relationship-building between staff and service users (Berry et al., 2016; Waugh et al., 2010; Summers, 2006), thus reducing the use of coercion (see Chapter 2).

Given the function and purpose of formulation (described in Chapter 2), some researchers have advocated for formulation to replace the use of diagnosis altogether (Johnstone, 2018a), or for formulation to be offered alongside diagnosis for added context (Mohtashemi et al., 2016), particularly for those with a diagnosis of BPD given its contested legitimacy (Campbell et al., 2020; see Chapter 1).

As discussed in Chapter 5, in interviews with staff, there was a suggestion that formulation could assist with care-planning. This has been advised by NICE (Kuipers et al., 2014) during assessment and care planning for individuals with diagnoses including schizophrenia and psychosis (Kuipers et al., 2014). Other researchers have described positive appraisals of staff towards the utility of formulation for care-planning as well (Bensa & Gregg-Rowbury, 2016; Craven-Staines et al., 2010; Summers, 2006). Yeandle and colleagues (2015) describe the use of a 'guided formulation' to lead care-planning throughout Somerset Trust. Thus, the exploration of formulation to both support and extend positive practices on Poppy ward and potentially beyond was clearly justified.

7.3 Determining What Makes a 'Good' Formulation

The UK appears to be the only country in which the governing body of Psychology has issued official guidelines on formulation standards. In the UK, the DCP is responsible for formulation guidelines for clinical psychologists. The current guidelines were assembled in 2011 and highlight key characteristics of formulations from all orientations, with the expectation that "clinical psychologists always formulate from a broad-based, integrated and multi-model perspective which locates personal meaning within its wider systemic, organizational and societal contexts," (DCP, 2011, p. 2).

The 34-item checklist offered in the good practice guidelines specifies that formulation should, among other features, be sufficiently grounded in thorough assessment, go beyond a mere list of factors to integrate an explanation of an individual's difficulties, adequately contextualises relevant historical experiences, uses personal meaning as an integrating factor, and provides the foundations on which to base treatment planning (DCP, 2011).

Additionally, the checklist highlights the importance of basing the formulation on the person and not their diagnostic label, the use of accessible language, as well as cultural sensitivity.

Over the years, critics have questioned the idea of scientific validity and rigour as it applies to formulation. Specifically, some have expressed concern over a lack of demonstrable reliability and validity within various formulation models (Messer, 1991; Mumma, 2011; Mumma & Fluck, 2016). Ridley and colleagues (2017) argue a case for more 'valid and reliable' formulation methods, predicated on 1) a need for a consensus definition of formulation; 2) the plethora of models; 3) the disconcerting status of clinical judgment; and 4) pervasive judgmental and inferential errors. Ridley and colleagues (2017; as well as others who share their view) seem to view 'validity' through a positivist lens, or 'scientific validity;' however, this is with little to no reference to the views or role of a service user in its development. Ridley and colleagues (2017) do not show any indication as to whether their suggestions for internal checks to ensure robustness of internal 'validity' would actually help the service-user. Their role is not to actively engage with this process; they are considered a source of information to be integrated but not to consult or collaborate with.

This research adopted a similar view as the DCP good practice guidelines on formulation (2011), which are largely unconcerned with 'validity,' 'accuracy' or the rigour of 'scientific' methods of formulation. Test-retest reliability or examination of 'truth' of a formulation against 'evidence' does not address the purpose of formulation according to the DCP, which is to assist a service-user to explore the meaning of their experiences as it manifests within their current problems. In addition, given the purpose of a formulation is to assist with therapeutic progress and the individual's recovery, such notions as test-retest validity are inappropriate: the goal is for the formulation to change, not for it to remain the same at a future time.

The DCP version of a good practice formulation (2011) entails an individual working collaboratively with a practitioner wherein they explore explanations and narratives that make sense to the individual and are helpful to their recovery; events or interpretations themselves are not tested for factual validity. Summers (2006) argues it is not, in fact, the content that matters to service users so much as staff attempting to understand and demonstrating their recognition of service users as people.

7.4 Types of Formulation

According to the DCP (2011), the main therapies used by NHS clinical psychologists include CBT, as well as systemic, psychodynamic, and cognitive analytic therapy (CAT). DBT is also a recommended psychological therapy for service users with a diagnosis of BPD

(NICE, 2009). Each of these modalities approach formulation according to the tenets of their theories and, if applied according to these parent theories without deviation, this can be viewed as a 'pure' approach. 'Pure' practices of modalities or the attendant use of formulation are uncommon (DCP, 2011). Both the basis of criticism by Ridley and colleagues and a recommendation in the DCP good practice formulation guidelines, most practitioners report to formulate from an integrative, 'eclectic' or mixed-model perspective. The rationale for this can also be explained by both schools of thought: formulation is often a practice that is ill defined or unclear even to senior clinical psychologists (Upsdell, 2018), and perhaps due to a lack of prescription, an eclectic formulation is the unintentional result. An eclectic approach aligns with recommendations by the DCP (2011) in that it suggests practitioners approach each individual with a broad view and the best evidence of 'what works', irrespective of the particular theoretical orientation.

Other models are described as 'theory-neutral,' or compatible with a range of therapeutic orientations (Kendjelic & Eells, 2007). However, common 'theory-neutral' models tend to incorporate key factors or elements common to most formulation models that generally map roughly onto the CBT 5-P model (presenting issues, precipitating factors, perpetuating factors, predisposing factors, and protective factors; Kendjelic & Eells, 2007). The 5-P model and those like it, it should be noted, have been criticised for exemplifying a type of 'list of factors' approach, which limits a more cohesive and meaningful narrative when applied uncritically (DCP, 2011).

Traditional formulation takes place one-to-one between a practitioner and a service-user, although it has been suggested that carers or chosen members of an individual's care team may also attend with the service-user's permission (Tarran-Jones et al., 2019). Team-based formulation, or the concept of involving a wider staff group in formulation as traditionally practiced by psychologists, has more recently received attention (Randall & Caldwell, 2015). In the literature, team-based formulation can be the team formulating either the service-user based on their individual knowledge and interpretations of what is happening with the service user, or their reactions to a service-user (for example, as a reflective practice exercise), or both.

7.5 Collaboration in Formulation

Collaboration in the development of psychological formulation tends to refer to collaboration with the service user, collaboration with the MDT, or both. Collaboration with both service users and staff aligns with the DCP (2011) good practice formulation guidelines,

although some may argue that best practice formulation would prioritise service user input due to increasing awareness of the ethical dubiousness of 'doing unto' versus 'doing with'. As described in Chapter 2, service users value being involved in their care. Beyond arguments that involvement is a right (Sheldon, 2011), it is additionally thought to avoid the negative ramifications of incorrect or re-traumatising formulations (Redhead et al., 2015).

Service user collaboration in the team-based formulation process has been described as depending on the nature of the formulations; for example, reflective practice may not be appropriate for service-users to attend (DCP, 2011). Based on current research, it is not clear how service users can be meaningfully, ethically and logistically involved in team-based formulation, although solutions have been offered (Ingham, 2012).

7.6 Critique of Existing Models

Although notable exceptions exist (Kuyken et al., 2009), strengths or more positive aspects of care tend to be constrained to one separate section of a formulation, which may have the symbolic impact of downplaying its presence or importance. This is an important feature to overlook, as focusing on problems, while an obvious and necessary aspect of acute care, may deny hope to service users in the absence of more encouraging messages about their worth and potential.

Very few models, again with a notable exception (Yeandle et al., 2015), are indicated to have been collaboratively developed. Yeandle and colleagues (2015) describe their 'guided formulation' approach as being developed for working with service users with a diagnosis of BPD describe the development of the Model "by the authors of the present article alongside feedback from a range of staff and service users" (p. 26). The authors emphasise the formulation is 'jointly undertaken.' They refer to an 'explicit format' that supports collaboration but the model itself is not provided for public review. The authors also do not make clear what features of the model have been adapted for use with service users with a diagnosis of BPD or why other models are unsuitable.

A critique of mainstream models (for example, CBT) is that they tend to fail to sufficiently acknowledge wider contextual causes of distress (Johnstone et al., 2018; Proctor et al., 2009). Similarly, biopsychosocial approaches, although ostensibly more holistic, have been criticised for privileging biological explanations of mental distress (Johnstone et al., 2018).

In one of the few articles that address the experience of the process of DBT formulation, Rizvi and Sayrs (2020) briefly discuss their observations over the years of

delivering DBT training to clinicians. Although the article itself focuses on simplifying the principles of DBT, it is positioned to do so given the experiences of delivering DBT as complicated and 'extremely daunting' given its complexity. Although experts and those with extensive training may find the process of DBT formulation straightforward and adaptable (Rizvi & Sayrs, 2020), its being taught to all members of the MDT would likely be difficult.

Although likely more straightforward to teach to formulation novices, the list-of-factors approach (such as that typically demonstrated by the 5-P model) may limit the coherence of a formulation. The DCP (2011) guidelines recommend using meaning as a narrative glue to thread together a comprehensive and understandable rendering of a person's experiences and plan.

7.7 Identification of Gaps and Rationale for Development of the PNM

This review reveals the existing gaps in the literature, including the need for the development of a formulation model that recognises and integrates service users' positive aspects throughout the process; clearly indicates a process of collaboration with various stakeholders that is applicable regardless of psychiatric diagnoses; addresses the wider contextual influences on individual mental health; is straightforward for non-psychology staff to understand and implement; and uses personal meaning to integrate its various components. For this research, there was also an impetus to, as far as possible, develop a model that addressed the needs of staff and service users (see Chapters 5 and 6) by using their guidance and feedback to incorporate relevant features of existing formulation models and theories to ground the resulting model in their lived realities. This approach sought to avoid the risk of developing a rigid model that was incongruent with reality, which may otherwise result from the development of a theory-driven model without reference to end users. The model is intended to encourage attendance to and prioritisation of need rather than theory in a strict sense (Spandler, 2021). The developed model came to be called the PNM and an account of its process of development is provided below.

7.8 PNM Development: Ties to Theoretical Framework

The critical realist perspective aligns with the underlying philosophical assumptions inherent in the PNM. As discussed within Chapter 4, critical realism is distinct from other philosophical perspectives in terms of its ontological realism, epistemic relativism, and judgmental rationality. Ontological realism entails the view that events in the world occur

independently of our awareness, which aligns with the Model's objective to identify meaning within the lives of services users and their understanding of how their difficulties developed. The Model also aligns with critical realism's epistemic relativism, which views knowledge of reality as situated in a historical, social, and cultural context (Archer et al., 2016). The foundation of the model is the acknowledgement of an individual as situated in their broader political, social, and material environment and how it is embodied in the individual and their mental health. Finally, the PNM aligns with critical realism's position on judgmental rationality, which Archer and colleagues (2016) frame as the belief in the possibility for social science to improve its knowledge about reality over time, and to make relatively justified statements about the 'real world' while at the same time being historically and contextually situated, and subject to change. The PNM, being a model of psychological formulation, seeks to assist the service user to identify the central role of meaning in their experiences and to test hypotheses about how best to assist in coping with distress by evaluating interventions.

The PNM is not intended to be interpreted as a 'final' version. Aligning with the critical realist perspective, it is subject to questioning and improvement through consultations with a larger audience of stakeholders as well as research, and the involvement of key collaborators throughout the process is merely the first stage.

7.9 Guiding Documents and Models

A host of guidelines, theories, and published models of formulation provided the foundations of the PNM. Key concepts and features of these works were incorporated and adapted according to the guidance and feedback of key contributors.

Beyond the DCP's 'good practice guidelines for psychological formulation' (2011), other resources and documents which guided the development of the PNM included incorporation and reference to key strengths-based approaches (Tse et al., 2016) and models, including the strengths-based Client Assessment of Strengths Interests and Goals (CASIG; Wallace et al., 2001). Also incorporated were the CBT-based Comprehend, Cope and Connect model (Clarke & Nicholls, 2018; Bullock et al., 2021); and the team formulation approaches outlined by Johnstone and Dallos (2014), among others (Kendjelic & Eells, 2007; Berry et al., 2016; Hagan & Smail, 1997).

The most influential document and therefore the focus of the following discussion is the PTMF (Johnstone et al. 2018), which was published by the British Psychological Society's (BPS) DCP in January of 2018. The authors of this document, identified as a 'meta-theory'

that supports and extends existing contextual ways of viewing mental health, set out to present an alternative to the 'DSM mindset' (Johnstone et al., 2018). The authors claim the currently accepted view of mental health difficulties is inappropriate because it depicts mental health difficulties as internalized, largely biologically caused illnesses to be understood similarly to medical diagnoses. They claim that a paradigmatic shift is possible and necessary. According to the authors, the fundamental purpose of a diagnosis is to understand patterns, and that this can occur without reference to psychiatric diagnostic models. The document was co-produced by researchers, practitioners, and people with lived experience.

The authors indicate the ideas presented within the PTMF apply to all people, rather than just those who use psychiatric or forensic services. The Framework (Johnstone et al., 2018) adapts the question made popular through the recovery movement: 'What has happened to you?' (How is Power operating in your life?) This question is expanded to delve further by asking the following questions:

- 'How did it affect you?' (What kind of threats does this pose?)
- 'What sense did you make of it?' (What is the meaning of these situations and experiences to you?)
- 'What did you have to do to survive?' (What kinds of threat response are you using?)
- 'What are your strengths?' (What access to power resources do you have?)
- 'What is your story?' (How does all this fit together?)

Beyond its conceptual impact on the development of the PNM, this document was also a source of practical guidance regarding how to structure the PNM, adapting and incorporating these questions throughout.

Along with the widely acknowledged psychological, sociological, and biological factors, the Framework views mental health difficulties as the embodiment of material and political contexts and acknowledges the common experience of trauma amongst those who use services. The Framework acknowledges the often-unseen power influences in society at large and conceives people's reactions to the negative operation of power to be understandable reactions, or threat responses. The meaning that individuals take from their experiences serves to unite the narrative of a person's life, allowing an understanding of their reactions to specific circumstances, and serving to illuminate their patterns of behaviour.

The PTMF has not been without critique, and this is important to acknowledge and address given the centrality of the Framework in guiding the PNM. In this age of web-based publication, much debate has taken place on non-traditional forms of media. The PTMF's

publication in January 2018 was followed by personal opinion pieces on blogs, interaction between authors and the public through social media, podcasts, and text-based debates (Johnstone & Whittaker, 2018).

Examples of criticism include (1) that it dismisses or misrepresents biological/medical/genetics factors and de-emphasizes the influence of biology on mental distress, or, in other words, overemphasizes the influence of socio-political factors. The authors have also been accused of (2) failing to consult with enough service users or activists in social justice issues sufficiently (particularly members of racialised groups), and perhaps as a result of this, that (3) it does not sufficiently consider the real-life implications of social inequality and epistemic injustice and furthermore does not offer solutions to either. Further criticism is that (4) it uses recovery to pit psychology and psychiatry against each other, using this document to wage its 'turf war.'

Much of the criticism has been addressed by the authors directly (Brown, 2018). To criticism (1), the authors have countered that the Framework acknowledges the role of biology but contends the current conceptualization of biology as the most important influence is un-evidenced; for example, the existence of biomarkers of psychiatric diagnosis (Venkatasubramanian & Keshavan, 2016) and the theory of 'chemical imbalance' have continued to remain unsubstantiated despite decades of well-funded research (Border et al., 2019; Harrington, 2019).The fact the research has not yet been able to evidence the role of biological influences despite decades of funding suggests new ways of understanding mental illness which are not based on the role of biology are required. Further, the authors acknowledge the role of biology as "a mediator and enabler of all human experience" (Johnstone et al., 2018) as opposed to a primary cause, which introduces a much more nuanced and complex understanding of mental health, and one which appears to more closely fit reality. The second (2) criticism that the authors failed to sufficiently solicit the perspectives of service users and other stakeholders was perhaps justified in that over the course of the 5 years during which it was developed only 8 service users and carers were consulted. Although this was supplemented by two contributing authors who also identify as having lived experience of mental health difficulties, the critique posted on the National Survivor User Network blog (Scheherazade, 2018) following the event highlights the absence of diversity among the panel, which underscores a far more insidious and systemic concern surrounding the undeniable absence of intersectionality among authority figures in mental health, who are predominantly white and from privileged backgrounds.

The third (3) criticism surrounds the impracticality of the model being employed in current services. This particular critique is somewhat unjust given the Framework has been presented by the authors as a first stage of the project and that further work is required to make it more concrete. The Framework was introduced as a primarily intellectual resource which is not expected nor intended to be put into practice at this stage. The authors acknowledged the need for adherence to the current ideology within the current context, including the requirement in some social assistance programs for a diagnosis. The authors additionally acknowledge that some service users find meaning and comfort within the current system and wished to simply offer an alternative way of thinking which is not offered in the prevailing system. Finally, the document was not published without consultation with experts and professionals in the area of social assistance, including feedback from the Professional Head of Social Care and Social Work at an NHS Trust. He and other consultants provided guidance on navigating the wider societal and political atmosphere and on how the Framework could be adapted for use in practice. Again, criticism from those such as the blogger who provided an opinion to the National Survivor User Network (Scheherazade, 2018) is valid in pointing out the absence of consultation with activist groups who may have provided more practical feedback which in turn could have been more acceptable to a broader range of intended end-users.

Whether or not the fourth (4) criticism was the intention of the authors, that is, to pit Psychiatry against Psychology, the model certainly seems to have instigated a degree of hostility and defensiveness from both sides and can be seen be playing out on social media, specifically Twitter. As Dr Johnstone (Johnstone, 2018b) states, the reaction on the part of Psychiatry as expressed by certain psychiatrists is somewhat predicted by the model itself. Because the authors of the model intend to challenge the authority and credibility of prevailing bio-centric ideology, it follows that representatives and those who align themselves with the tenets of the diagnostic and medical model would react defensively by using threat responses themselves. Criticism has been both constructive and not. Critics also claim the authors fail to acknowledge that Psychology profits from the current ideology, and the authors have been called un-reflexive for this lack of acknowledgement. Although this was not directly addressed in the Framework, or at least from what I observed, the authors do acknowledge that a Psychological or service-based approach may not always be helpful for service users and there are many less formal, non-formulation-based ways of locating meaning and promoting personal recovery. In addition, the authors have elsewhere explicitly

challenged the vested interest of Psychology, a discipline in which professionals profit from distress (Dillon, 2016).

Despite some of the valid criticisms brought against the PTMF, I chose to draw from it in the development of the PNM due to my desire to provide those who wish it the option of an alternative and more contextual understanding of their difficulties. I acknowledge the PTMF is not without flaws, but it is an innovative and important model which supports alternatives to the prevailing ideology, one which can be damaging to service users and professionals (a proportion of whom identify as having lived experience) alike (Richards et al., 2016).

7.10 Iterations of the Model

7.10.1 Major Contributors

The SUAG (see Chapter 4) assisted to develop the PNM from its earliest stages onwards. Their lived experience assisted to enhance the relevance and presumed acceptability of the Model (explored empirically in Chapters 8 and 9).

Due to the NHS gatekeeper's life events, including career moves and maternity leave (see Appendix A), I benefitted from the perspective of four formal and one informal NHS supervisors for the applied aspect of the research. All four supervisors are mental health practitioners, and although each encouraged me to exercise independence in my final decisions, they provided unique guidance and perspective according to their professional experience and underlying worldviews. Two supervisors are clinical psychologists, and two consultant psychiatrists. Perhaps predictably, the largest diversion of opinion regarding in what direction to take the model was between the psychiatrists and the two psychologists. One psychiatrist supported a formulation model similar to the 5-P model (Dudley & Kuyken, 2014) model and was in favour of a 'clinical' formulation informed by staffs' immediate needs whereas the initial psychologist supervisor was careful to differentiate between clinical formulation and psychological formulation, the latter being more concerned with psychological theory and drawing from evidence-based psychological models. Both clinical psychologists expressed interest in the PTMF (Johnstone et al., 2018), a DCP Psychology model.

The input from my academic supervisory team combined professional expertise with expertise in applied research. My supervisory team guided me to reflect on the philosophical and theoretical coherence of the model with the overall worldview of the research project; the extent to which decisions I made were defensible and logical; as well as ensuring the

relevance and quality of guiding resources. My supervisory team also assisted in navigating the frequently conflicting feedback from the SUAG and the NHS supervisors, which required careful consideration to resolve.

7.10.2 Development Process and Model Iterations

The model underwent three distinct iterations (see Table 7.1). The original design of the model entailed a CBT 5-P formulation model, common in research relating to formulation interventions (Bensa & Gregg-Rowbury, 2016; Brown et al., 2018). This involved the problem, predisposing factors, precipitating factors, perpetuating factors, and protective factors. This was the presumed model for much of the beginning stages of the research given it took several months for the SUAG to assemble properly; without the contribution of stakeholders, the model itself was little changed from its original conceptualization.

Table 7.1

Feedback and Iterations of the PNM

Guidance/feedback	Source	Version
Must be collaborative	Consultant psychiatrist	Pre
Use of term 'formulation' too clinical	SUAG	Pre
Clinical language makes people feel intimidated and self-conscious	SUAG	Pre
Include positive aspects of history	Clinical psychologist	Pre
Use more neutral phrasing, e.g., 'what happened'?	SUAG	1
Not focusing on strength, language still too clinical	SUAG	1
Use more recovery-aligned language and language service users themselves would use. E.g., 'triggers'	SUAG	1
Do not refer to 'horrible feeling'	SUAG	1
Staff need to be assigned more responsibility in process	SUAG	1
Create more guidance or a manual for staff to make more accessible	SUAG	1
Make more individual, allow to be more tailored to each service user	SUAG	1
Use PTMF more as existing framework	Supervisor/clinical psychologist	2
Make strengths/resources more explicit with box/question	Supervisor/clinical psychologist	2
Good that next steps included, makes more concrete	Supervisor/clinical psychologist	2
Model very clearly about ward life	Recovery tutor	3
Good to emphasise fluidity of process; ensure service users know can proceed at own pace	Recovery tutor	3
As questions go on, recognises strengths, leads service users to identify positive aspects	Recovery tutor	3

As the project developed, however, there was concern about how to balance the Model's contribution to knowledge, integrating the practical suggestions made by the SUAG and the need to acknowledge societal-level influences. This necessitated an approach that both addressed a broader understanding of politics, as well as social and psychological factors. There was also a need to adopt a 'transtheoretical' model, which "is not constrained by the tenets or concepts of any one theoretical orientation" (Ridley & Jeffrey, 2017, p. 376). The freedom to incorporate techniques and principles from a range of therapeutic modalities based on their evidence also allowed for a more person-centred approach which could be adapted to a service user's particular needs, avoiding a 'bed of Procrustes' approach (e.g., figuratively shoehorning service users to fit a particular theoretical model; Bruch, 2015) and acknowledged that no one intervention is right for every problem or person; thus, a CBT-based model was deemed inappropriate. Feedback from the SUAG also pointed to the need for more focus on strengths along with the need for the model to be grounded more concretely in the ward to ensure its relevance for service users. The feasibility of the scope of interventions given the time-limited nature of service-user stays at the recovery ward was also a consideration in ensuring the scope of the Model did not exceed realistic timeframes. There was also a concern the model was still much too clinically focused and would not be accessible to service users.

This feedback led to the second distinct iteration of the model; this version was heavily strengths-based and grounded in experiences on the ward. The feedback from the SUAG was especially influential in this iteration of the model: the incorporation of strengths was represented more fully within the guided discussion included in the elaborated version of the model, and service users were encouraged to explore their own resources and goals. The model was very much solutions-focused in that the objective was to identify a concrete plan of action to support the service user in areas they identified themselves. The model was further supported by a member of the local Recovery College, who remarked the pattern of guided questions intended to encourage service users to identify their own strengths was especially helpful, as it encouraged self-reflection on existing resources and supports, and demonstrated this in a pattern so the message is more discernable even to those service users whose usual cognitive resources may not be fully available because of medication.

The final version of the model evolved from the closing round of feedback from one of my academic supervisors, a clinical psychologist, who felt the model had become somewhat pragmatic and offered fewer opportunities than was ideal for psychological theory to contribute to the service user's understanding of their difficulties than was ideal. In

focusing on the contribution of the SUAG, I had somewhat lost sight of psychological theory. Thus, I revisited the Model with the relevant literature in mind alongside the SUAG and other feedback once more. The final model was developed by incorporating feedback from all stakeholders' consultations in a way that allowed for flexibility and refrained from imposing on its users any one way of working or understanding. It is based heavily on the PTMF (Johnstone et al., 2018) given its alliance with formulation and trauma-informed recovery principles, as well as an awareness of the wider influences of political, social, psychological, and biological factors as interdependent and inseparable mechanisms and influences in people's lives.

The SUAG made specific and concrete suggestions to ensure the acceptability of the model. This included replacing the term 'formulation' with more everyday language to improve its accessibility to both service users and non-Psychology staff, which led to the adoption of the term 'personal narrative.' Containment was also a concern for service users, who felt that without appropriate delineation of the purpose and framing of the model, service users would feel overwhelmed by the scope of conversations and be less likely to identify goals or specific support requirements. Thus, it was recommended the model be grounded within the inpatient ward experience to provide structure and direction to the conversations between service users and practitioners.

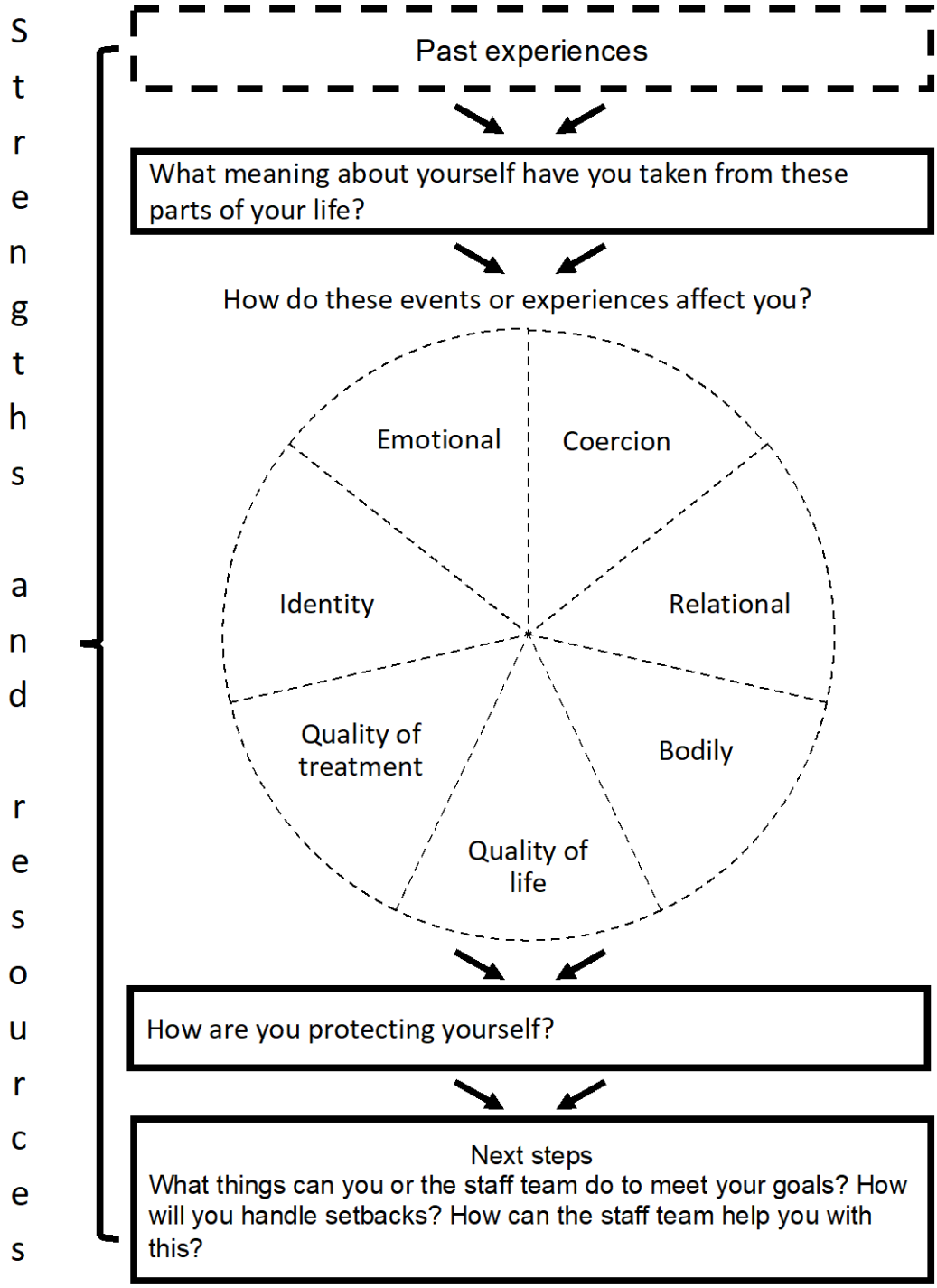
7.11 The Personal Narrative Model

The final formulation model (see Figure 7.1 and Appendices E and F for templates and guides) drew from the literature in a variety of respects, ranging from its format, its content focus, and the ultimate messages it was intended to deliver. The format of the model, as suggested by existing frameworks and aligning with the need for flexibility and sensitivity in acute psychiatric services, was designed to be flexible and not intended to be rigidly adhered to, nor are its sections exhaustive. In terms of its topics covered, their relevance has been grounded in the literature, the recommendations of the SUAG, and various other contributors. It includes the areas of life in the ward which are predicted by contributors to be salient to end users (service users and staff). Although the linear format and delineated sections of the model may imply users should work their way from the top down (for example, beginning with past experiences), this orientation it is not to be understood as 'directions' as such. The users of the model may wish to choose which section(s) to focus on and the order in which to explore them. Each section is to be understood to affect and be affected by every other section, and in this way, no section may be viewed independently or

outside of the context of the rest of the Model. This accords with the PTMF authors' explanation (Johnstone et al., 2018) on how best to understand that particular model, and which, as stated above, heavily influenced the development of this model. This is explained in greater detail in the following sections.

Figure 7.1

The Personal Narrative Model



7.11.1 Collaboration

As described in Chapter 2, collaborative mental health practices are integral to positive experiences of mental health services; as further emphasised in Chapter 7, this is also the case for positive experiences of psychological formulation. Collaboration forms one of the key principles of good practice of psychological formulation by the DCP (2011). In this way, the contributions of both the service user and the practitioner are valued equally. In practice, the service user and practitioner should agree on the formulation that is written down. The PNM is intended to be used as a tool according to the needs of its users and therefore can be used one-to-one between a service user and a clinician; to formulate as a staff team; or, as was the original design of this research (see Appendix A), both.

7.11.2 Strengths and Resources

Intended to inform each subsequent section of the model, strengths and resources symbolically runs continuously along the side (see Figure 7.1). Following from consultation with the SUAG as well as the site-supervisor clinical psychologists, the model is intended to focus on the strengths and resources of the service user. According to the section discussed between the clinical psychologist and the service user, this will involve a consideration of their positive qualities, characteristics, or experiences. The formulation and psychotherapeutic literature were consulted for examples of strengths-based approaches; the result was Tse and colleagues (2016); Padesky and Mooney (2012); and Wallace, Lecomte, Wilde, and Liberman's CASIG (2001): A consumer-centred assessment for planning individualized treatment and evaluating program outcomes. Each succeeding section requires the practitioner assist the service user to identify 1-2 positive things about themselves as it relates to that particular section.

7.11.3 Past Experiences

This section, as in the PTMF (Johnstone et al., 2018) expands on the question, "what happened to you?" The border of the past experiences box in the model is symbolically perforated to indicate it is not to be considered a focus of the formulation discussion and that it is not to be seen as a definitive feature of the individual, an idea introduced by Clarke and colleagues (2018) in their CBT-informed Comprehend, Cope, and Connect model. This section in the PNM template for the service user to complete is contained within a box. This

was conceptualised in response to concerns of the SUAG for the need to contain the discussion within the practical time to be allowed for the session.

According to Read and colleagues (2018), 0 to 22% of service users report being asked by services about their histories of abuse or trauma, which appears poor practice given that research suggests individuals who have experienced physical and/or sexual violence are more likely to come into contact with services (Brooker, Toque, Brown, et al., 2016; Read et al., 2008). Informed by the aforementioned research and others, including Brooker, Toque, Kennedy and colleagues' Care Programme Approach (2016), this formulation model includes this section to explore the past history of the service user and provide an opportunity to acknowledge but not focus on their previous experiences, as suggested in the literature (Clarke & Wilson, 2009). Although it can logically be anticipated that service users will identify negative past experiences, this space encourages acknowledgement of both positive and negative historical events.

7.11.4 Meaning

This section expands on the question posed by the PTMF (Johnstone et al., 2018), "what sense did you make of it?" The inclusion of the meaning section has been heavily influenced by the feedback of the SUAG and practitioners regarding the areas of immediate concern for stakeholders. It has borrowed heavily from the PTMF (Johnstone et al., 2018), which, as alluded to by its name, is focused on exploring a service user's distress through the meaning adopted and created by the service user themselves. The list of possible meanings, not to be taken as exhaustive, has been adopted from the PTMF (Johnstone et al., 2018). With reference to the suggestion of the SUAG as well as my academic supervision team, the addition of possible positive meanings have been included at the top of the list to symbolically ensure they are given priority in their consideration.

7.11.5 Threat

The threat section, which, like the PTMF (Johnstone et al., 2018) expands on the question, "how did it affect you?" has been heavily influenced by feedback from the SUAG and practitioners, with particular regard to the areas of immediate concern for stakeholders; CASIG (Wallace et al., 2001); and the PTMF (Johnstone et al., 2018). The format of the wheel draws on Hagan and Smail's model of power-mapping (1997), and the sections map roughly on the general areas identified by those authors, including Containment, Relational,

Bodily, Quality of Life, Quality of Treatment, Identity, and Emotional. The refinement of these sections was conducted in collaboration with the SUAG, who helped to ground them to the specialist ward setting to ensure the model's relevance to its end users.

7.11.6 Threat Responses

This section expands on the question posed by the PTMF, "how are you protecting yourself?" The inherent message here is that as a consequence and cause of the service user's past experiences, the meaning they draw from them, and how it is affecting them serve to influence their behaviour (in clinical language and common parlance, their symptoms). With this guiding principle, this behaviour, although it may not currently be adaptive, served an adaptive or survival purpose for the service user at some point which may no longer be helpful or acceptable to them or others. The template provides examples of threat responses and the functions they serve which, by no means exhaustive, provide scaffolding for the idea to be conveyed and to assist both the clinical psychologist and service user to begin to explore the service user's behaviour.

7.11.7 Next Steps

The format of the guided conversation found in the template (see Appendices E and F) draws on CASIG (Wallace et al., 2001) in determining whether a particular area is relevant for the service user. Following this, the model asks whether they would like to improve this area, whether they require assistance to do so, and what resources they have to accomplish their goals (Wallace et al., 2001). In response to SUAG and practitioner feedback, the discussion surrounding resources available to assist with the realisation of goals may need to be directed by the clinician. The format of the guided conversation received positive feedback from the SUAG and an instructor from the local Recovery College, where service users are encouraged to begin by repetition to identify the resources, they have access to around them, including their own personal qualities, and begin to quantify what assistance they may require.

This component of the model was strongly influenced by the SUAG and practitioner input as well as the literature on formulation (Bliss, 2014). A common criticism of formulation practices appears to be that all too frequently it does not result in concrete goalsetting or tasks to effect required change. The identification of goals for both the service

user and the team assisting in the achievement of these goals makes the formulation task practical.

7.12 PNM Training Development

The rest of this chapter describes the development and delivery of the training on the PNM delivered to Poppy staff. Quantitative data relating to outcomes was collected before and after the training but ultimately omitted from the substantive thesis given insufficient numbers (see Appendix B for the data).

In line with the NICE (2014) publication relating to behaviour change, the intent was to deliver a 'very brief' but intense intervention; a time-limited intervention was also necessary given the restraints on time within Poppy ward. The training involved 4 x 1.5-hour sessions over the course of 30 days; thus, the total length of the training was 6 hours (although as described below, no participants attended all four sessions). This is comparable to smaller-scale interventions, such as Shaw and colleagues (2017), who ran a half day of advanced formulation training in addition to a half day of basic formulation provided in their professional training, although generally training of this nature tends to involve a longer commitment, although not excessively so. For example, Buchanan and Shocolinsky-Dwyer (2016) offered four sessions of two-and-a-half hours; Casares and Johnstone (2015) offered the equivalent of a day. There is some evidence to suggest that longer training sessions may not always yield superior results; DeViva (2006) did not find a difference between a three- versus 6-hour training session.

A collaborative approach to training was adopted. Not being experienced in the delivery of training, particularly in training practitioners and mental health professionals, I approached the training flexibly and was prepared to amend the sessions as they went on according to the needs and feedback of the attendees. This also aligns with NICE general guidelines on behaviour change (2007), which advise that interventions should "take account of the social, environmental and economic context of behaviours" (2.5 section) to effectively deliver results.

The training was amended according to expressed needs as it progressed. For example, one staff member suggested seeing a completed example of the PNM with a hypothetical service user in mind; this was shared in the final training session.

NICE (2007) advise to employ a range of behaviour change methods and approaches, according to the best available evidence. Although it was beyond the scope of this research to conduct audits and provide feedback per a Cochrane review (Ivers et al., 2012), empirical

research relating to training mental health professionals on psychosocial interventions demonstrate efficacy using multimodal approaches (Herschell et al., 2010; Ravitz et al., 2014). Ivey (2006) also provided a description of the best practice of teaching psychological formulation. Findings from these studies recommended the use of multimodal, interactive lesson plans with simulations, role-play, observation, and feedback along with reflective discussions and printed materials. Therefore, the intervention consisted of four PowerPoint presentations interspersed with videos, roleplay activities, and prompts for discussion. The training was intended to facilitate a collaborative exploration between the staff and myself of how the Model could be applied to practices on the ward. Opportunities to practice using the Model were also built into sessions. Finally, as indicated from the findings of Giguère and colleagues' 2012 Cochrane review and its moderate impact on positive results, between-session assignments ('homework') combined with interactive lessons was also recommended to participants.

The content of the training sessions was modelled on other theses (Maclean, 2013; Richmond, 2014; Tudor, 2014) given their extensive explanations and their provision of an indication of realistic pace and scope of topic.

Besides conveying knowledge of the PNM to participants, the training overall was intended to instil a positive attitude towards the PNM and its potential to improve service user and staff outcomes, as well as enhance staffs' sense of self-efficacy, both recommended by NICE (2007) to effect behavioural change.

7.13 Training Itinerary

Table 7.2 provides a summary of the training itinerary.

Table 7.2

Staff Training Itinerary

Pre-workshop	Baseline measures taken (questionnaires and formulation evaluation).
Session 1	
	Introduction, setting the scene.

Session 1.1	Highlight opportunities within the service.
Session 1.2	Introduction to the PNM; model and research development process, resources.
Session 1.3	Discussion: Compatibilities and tensions between DBT and PNM.
Session 2	
Session 2.1	Review of the PNM.
Session 2.2	Discussion: Application of the PNM.
Session 2.3	Example PNM: watch a short video of a service user and in pairs, role play the service-user and the clinician using the PNM.
Session 2.4	Discussion: Experience of applying the PNM.
Session 2.5	Formulation: good practice.
Session 3	
Session 3.1	Review of the PNM.
Session 3.2	Activity: identify a service user who can be role-played; explore the ways forward section of the PNM.
Session 3.3	Collaboration and service-user involvement.
Session 3.4	Enablers and Barriers to implementing the PNM.
Session 3.5	Discussion: what are some enablers and barriers relating to formulation practices?
Session 4	
Session 4.1	Review of PNM.
Session 4.2	Example PNM.
Post-workshop	Formulation evaluation to be conducted with staff. Formulations based on a sample vignette.

Session 1 involved introducing the topic of formulation, the PNM and its development process. The session concluded with a discussion of the similarities and differences between the Model and the ward's current practices.

Session 2 began with a review of the PNM, followed by a discussion of its application. Staff then viewed a short YouTube video of a service user explaining her history and experience of her mental health difficulties which was followed by an activity in which they were to roleplay the service user and a clinician, using the PNM. There was then a discussion regarding staff experiences of applying the PNM, followed by a review of good practice guidelines.

Session 3 was co-facilitated alongside one of my academic supervisors, Dr Jonathan Totman, a clinical psychologist. This session again began with a review of the PNM, followed by an activity for staff to form pairs and identify a service user to be roleplayed (whilst observing confidentiality rules) to simulate completing the 'Ways Forward' section of the PNM. I then offered suggestions and techniques explored in the literature relating to meaningful service-user involvement in the development of a formulation. This was opened up for discussion with the group. I then introduced the enablers and barriers of formulation practices found in the literature, followed by another facilitated discussion with the group relating to possible barriers and enablers that may facilitate or impede the application of the PNM.

Session 4 was a review of the PNM followed by an example of a completed PNM based on a real person (Judy Garland) facilitated by me.

7.14 Delivering the Training

In line with the recommendations of Forsetlund and colleagues (2009), times of day for the training to take place were identified in collaboration with the ward manager. These included times when handovers or staff educational meetings took place to ensure the maximum availability of possible attendees.

7.14.1 Preparation for the Training

At earlier stages of the planning process, I intended to include a co-facilitator, a trainer from the local Recovery College, in training delivery. This was not possible as the trainer who was initially approached was unavailable. I anticipated approximately 10 staff

members would attend each training session based on the number of individuals who had signed up to the research at the staff recruitment meeting.

7.14.2 Attendance at the Training

Seven staff attended the first training session, 6 attended the second, 5 attended the third and 7 attended the last. Issues were encountered with staff's ability to recurrently attend the sessions. No staff members attended all four training sessions. Three staff members attended three sessions each and three staff members attended two sessions each. The remaining ten staff members attended one-off sessions.

7.14.3 Training Delivery Challenges

Many of the training delivery challenges occurred due to the ward environment, limited availabilities of free staff, inconsistent rota, and other commitments on the ward including handovers, ward reviews, therapy sessions, and other requirements. The nature of the staff rota and the logistical difficulty of training all staff was not accounted for despite Buchanan and Shocolinskiy-Dwyer's (2016) advice to do so.

The inconsistent numbers of attendees, although exaggerated in this case, may nonetheless align somewhat with that reported in the literature. Given that Brown and colleagues (2018) lost approximately 30% of their sample to attrition, and a 70% attendance rate reported per topic was reported by Buchanan and Shocolinsky-Dwyer (2016), this perhaps locates the challenges faced by this research within the reality of difficulties engaging busy professionals who work in demanding and unpredictable settings.

8. Chapter 8 Staff Focus Group

8.1 Chapter Overview

This chapter reports the findings of the Poppy focus group introduced in Section 3.4.2.1. The focus group took place 30 days following the staff training on the PNM. The aim of the present phase was to investigate the perceived acceptability, adoption, and appropriateness (Peters et al., 2013) of the Model and its application within Poppy using a variation of an implementation research design. Specifically, this focus group was conducted to understand staff experiences of 1) Poppy ward using a focus group methodology to enhance the richness of data (Lambert & Loiselle, 2007) as well as 2) their experiences of the staff training on the PNM as well as its implementation within their everyday practices.

The third research aim directed this phase of the research to explore the acceptability of the PNM in a specialist inpatient context. The fourth question is addressed.

4. What are specialist inpatient staff views of the PNM and its acceptability? What are the enablers and barriers?

8.2 Study Design

8.2.1 Context

As described in Chapter 1, this research took place at Poppy ward, a specialist ward for women with a diagnosis of BPD 30 days following the implementation of staff training on the PNM.

8.2.2 Methodology

The rationale for undertaking a focus group is provided in greater detail in Section 3.4.2.1. However, for the purpose of re-contextualising the present study, a focus group method was chosen due to the research questions relating to staff sharing and comparing their perspectives as well as the generation of ideas relating to the Model and its implementation (Breen, 2006).

The interview schedule was developed in reference to the literature and in reference to the results of the staff and service user interviews described in Chapters 5 and 6.

The resulting questions related to the following topics: 1) views about what, if anything, supported staff to implement what they had learned from the training to their practice as well any barriers encountered; 2) what they would change about the care-planning process; 3) whether they felt training on the PNM impacted their perception of service users;

and 4) what would prevent and enable staff to collaborate with service users on their treatment.

8.2.3 Procedure

After I verbally explained the Participant Information Sheet for the benefit of the members of staff who had not attended previous phases of the research and collected the signed informed consent forms, the focus group took place in a private meeting room off the ward where few disturbances were likely to occur. The conversation was audio-recorded using a password-protected device. The focus group was 50 minutes in length. A handout including a diagram of the PNM was distributed, particularly for the benefit of those staff who had not attended previous stages of the research.

8.2.4 Participants

Although staff who had participated in the training were invited to attend the focus group, a mixture of attendees attended (n = 7), two of whom had not participated in the training sessions (n = 2). For pragmatic reasons, including what was already a low number of participants, the decision was made at the time of the interview to allow all interested staff members to attend. One benefit of this decision was the offering of a possibility for the combination of generic feedback related to implementation of the PNM alongside that tailored to the PNM training could result in a richer conversation. In line with Terry and colleagues (2017), the number of participants who participated in the focus group exceeded 4 but did not exceed 8; in conflict with Terry and colleagues' recommendations (2017), only one focus group was performed rather than the 3-6 advised for a PhD project.

8.2.5 Ethical Considerations

Details relating to data storage and information security mirror those described in full in Section 3.7. At the time of transcription, all identifying information was removed or anonymised. All data has been kept confidential.

Mirroring the ethical considerations relating to staff participants described in Section 5.3.3, ethical concerns were identified, and a solution was identified as a condition of REC ethical approval. See Chapter 3 for further details.

8.2.6 Strategy for Data Analysis

The same rationale to use RTA (Braun & Clarke, 2006), described in detail in Chapter 3 and implemented in Chapters 5 and 6, applies to the following approach. Research notes taken throughout the training sessions described in Chapter 6 were also included in the analysis. Again, aligning with the earlier empirical chapters as well as the wider PhD project, the theoretical lens used for this study was a critical realist framework. The same transcription process described in Section 5.3.4 was undertaken.

8.2.7 Procedures for Assessing Reliability and Validity of the Analysis

The steps taken to assess and ensure the quality of this analysis parallels those taken in Chapter 5, including consulting with Poppy ward in June 2020, when positive feedback was received relating to the themes identified. The advantage of the focus group taking place following both the interviews and the training sessions was that I had interacted with most participants beforehand, which assisted in the development of rapport (Tarran-Jones et al., 2019) and is hoped to have enhanced the willingness and comfort of participants to volunteer honest, rich, and more nuanced responses.

8.2.8 Demographics

Four females and two male staff members took part in the research; one set of demographics is missing. The average age of participants was 39.5 with a range of 25 to 52. Years of training averaged 5.6, ranging from 2 to 17 years, and clinical work experience averaged 8.06 years with a range of .25 to 13 years. Participants had spent an average of 4.47 years in their current role (range of .25 to 12 years) and an average of 2.3 years working at Poppy (range of .25 to 6.17 years). A range of professionals attended, including a clinical nurse specialist; 3 nurses; 1 HCA; and an occupational therapist. The length of clinical work experience ranged from 3 months to 13 years.

8.3 Results

An RTA (Braun & Clarke, 2006) was performed on the focus group transcripts. Four themes were developed from the data: (a) Strings left untied; (b) Meet staff where they are at; (c) PNM could add meaning and coherence; and (d) The proof of the pudding is in the eating (see Table 8.1).

Table 8.1

Summary of Staff Focus Group Themes

Theme	Subtheme
Strings left untied	Concern around logistics
	Concern around risk
	Concern around SDM with the PNM
	Perceived or real role delineation around formulation
Meet staff where they are at	Involvement as 'food for thought'
	Building on and supporting current practices
	The importance of being accessible
PNM could add meaning and coherence	Care-planning feels divorced from other practices
	PNM could be helpful for care-planning
	Meaning and narrative could be helpful additions
	DBT formulation is limited
The proof of the pudding is in the eating	Benefits over time
	Multimodal implementation required
	Ongoing support and maintenance

8.3.1 Strings Left Untied

The first theme, 'strings left untied' describes the areas left unresolved, expressed by focus group participants as needing to be addressed to apply the PNM to this particular setting. As the staff training was designed facilitate a collaboration between me and ward staff and the Model's implementation left to be taken up by the ward to implement, it was learned at the focus group that for the most part, the PNM had not been taken up within the service.

8.3.1.1 Concern around Logistics. Staff felt that logistically, the training may have had a more meaningful impact had it been possible for the whole staff team to have attended. As it was, only a subset of staff was able to attend, the majority being at one-off stages and reflecting the rota-based ward schedule as well as the demands of providing adequate coverage to the 'ward floor'. As stated by Brandon, "I suppose it would be nice to have that for the whole team […] Um, and I think it could well have done then, if you see what I mean?"

Another discussion was around who would best be placed to deliver the PNM. As one participant (Sydney) highlighted, the MDT have various responsibilities and specialities, making the question of who is best placed to conduct the meeting uncertain:

> I guess I was wondering who would be-who would be doing this with an individual? Would it be, you know, there's a lot of staff; there's a lot of bother. So how you find one person, would it be the primary nurse or how would that-how-how would that work? […] Sort of gather-gather all of these information […] Because you've got the DBT therapist, who's going to be thinking about something, and then you've got a nurse. Um, you've got myself as an OT and then, you know, in theory a psychologist at some point. (Sydney)

In alignment with my intention to approach both the training and its application as a collaboration between myself and the staff as well as the intent of services to support the development of service user independence (DoH, 2015), another member of staff suggested the service user perform a majority of the work on the PNM.

> Brandon: "It comes with DBT, doesn't it, that structure."
> Sydney: "Okay."
> Brandon: "Um, and collaborating in structures, and I don't see why service-users don't do a majority of that work over time […] They've got a year. […] I suppose-I suppose the main nurse can do it over, I mean, once every four weeks."
> Sydney: "Yeah."
> Brandon: "I mean, just to really focus […] Um, I'm not sure, really, I sort of hadn't thought about that, to be honest. […] I suppose-I was saying, yeah, and the practicalities."
> Sydney: "Yeah."
> Brandon: "Um, I suppose that says more about me, doesn't it? So, I suppose that would be, wouldn't it? There's no reason why several nurses couldn't work on it, I suppose."
> Sydney: "No, I guess it's just that taking the lead. I like the ide-I'm more like the idea of the patient – "
> Brandon: "Mm."
> Sydney: "Doing."
> Brandon: "Yeah."

> Sydney: "I guess one person overseeing it, but actually if it was broken down for the individual to sort of be encouraged to think about [it]."

The idea of a service user taking ownership of their own narrative is one of the intentions of the PTMF, as is its use by laymen, by peer support groups, as well as by professionals; this follows the assumption that mental difficulties are not always best treated by 'professionals' and that social connection, purpose, and meaning are important in recovery (Shanks et al., 2013). In this view, ideological power thus may be transferred back to the individual building their own narrative, allowing them to assign their own meaning and describe their own understanding of the impact of their life's events and how they have coped with them.

8.3.1.2 Concern Around Risk. Another area of uncertainty expressed by members of the focus group was around risk and its containment while implementing the PNM. Whilst the ward advocates for PRT (described in Chapter 1), particularly in inpatient services and given the culture that exists in mental health services, preoccupation with risk is perhaps unavoidable. A particular concern raised with regards to the PNM was the potential for a conversation around 'what's happened to you'? to potentially be triggering and open up a discussion that a staff member may not be safe to contain:

> Sydney: "I guess I'm just thinking about the past experiences and how-how-how much detail would that involve, because that could fall into trauma."
> Researcher: "Mhm."
> Sydney: "Work and –"
> Brandon: "Mm."
> Sydney: "I guess it's-you know, it's between 'mum did this' and, you know, a detailed account of other events, so I wonder how you-then-I guess it's between caring—"
> Brandon: "Yeah."
> Sydney: "You know, you can open up, then, very, very troubling experiences, though I guess it would just be how to-because I saw this, and I thought, wow, that, you know-we've got some individuals here with some really horrific experiences."
> Researcher: "Mhm."
> Sydney: "So, it's how to contain that and manage it and sort of-it might just be a question for me, and thinking about the clinical confidence of people doing work, it's what to do with what could come out of that discussion."

This concern around the possibility of bringing up trauma due to fears of possibly worsening the mental health of a service user or being unable to manage distress can perhaps partially explain why many service users indicate they are not asked about what has

happened to them in services (Xiao et al., 2016). These fears may be symptomatic of a deeper issue within health services: the focus on accountability, liability, the fear of stepping outside the prescribed rules which are thought to take priority over the needs of service users (Felton et al., 2018).

8.3.1.3 Concern Around SDM with the PNM. Another area of unresolve brought up in the training sessions as well as in the focus group was how to manage a difference of opinion between service users and staff while constructing the narrative collaboratively. Perhaps because the training emphasised both parties' contributions being weighted equally, one staff member highlighted the possible challenge in addressing what staff perceive as problematic behaviour when this perception is not shared by the service user.

> Madison: "One of the interesting things is it's the same […] I'm just thinking that this paper kind of […] things like meaning of those. How it affects them. It would be interesting to see what that particular-because that could be from a […] sometimes you see things that they don't see."
> Sydney: "Mm."
> Madison: "[…] knowledge, or they think are justified behaviours. How do you challenge those? You know, they're yeah. […] what they should put in a given… what they should put in it."

This accords with one of the points raised in the training session Dr Totman attended, when the question of 'evidence' or 'truth' was discussed. One staff member described a hypothetical scenario where a service user claims a history of events that are not evidenced in case notes or by outside support, or where the experiences they describe are so outlandish as to be unbelievable. Dr Totman directed the conversation back to the importance of acknowledging and respecting the service user's truth, and through the lens of one of the PTMF, that their set of beliefs serves a survival purpose for the service user that may or may not be challenged in the course of treatment.

8.3.1.4 Perceived or Real Role Delineation around Formulation. The next area of unresolve was a perception of psychological formulation as a practice outside of nurses' remit, either being a psychology-exclusive practice or simply unfamiliar. This is a sentiment expressed in the literature (Grant, 2015), some speculating the medical model pervasive in mental health nursing leads to a lack of awareness of more psychosocially based understandings of mental health. As stated by Brandon, "I think 'cause formulation's still-it doesn't really seem to be nurses' […] [not sure if comfortable] With any of it."

This perceived misalignment was hypothesized as a cultural or educationally based practice, maintained through traditional role division.

> Brandon: "I wonder if it's a professional-in nursing, anyway-a professional issue there, and that's the […] plan. I mean nursing's very much set up, isn't it, from start to finish."
> Researcher: "Right."
> Brandon: Um, now I wonder if that-that would be an issue, if you see what I-and that language-that nursing language might be an issue.

There has been a rising movement to implement formulation practices across mental health professions, however (Skills for Health & HEE, 2017). As stated by Brandon, "I anticipate next year, you can see more nurses […] more engaged in formulation."

8.3.2 Meet Staff Where They Are At

'Meet staff where they're at,' captures the perceptions staff had about the training, particularly around predicting the course of its implementation given the realities of their practice. Much of what I encountered in the setup of the training sessions and in their implementation was reiterated by staff. Particular challenges included delivering the training to all staff, attendance at consecutive sessions, and for it to be embedded in practice.

8.3.2.1 Involvement as 'Food for Thought.' The training and Model were viewed as more of a thought exercise or 'food for thought' as Brandon put it, as opposed to being taken on actively in practice. One participant indicated that formulation was too obscure and far removed from their usual ways of working and that perhaps the training was 'too much too soon.' Brandon went on to further imply a lack of meaningful impact of the training and Model: "Um, I just suppose that people […] weren't quite ready to go straight to formulation."

Introducing psychological formulation to non-psychological multidisciplinary staff has been described as largely successful as measured through feedback questionnaires (Jones & Annesley, 2019); this poses the question of why the PNM seemingly did not meet the same reception. Being guided by a broadly non-diagnostic, socially and psychologically centred approach, doubtless there were aspects of the PNM that were challenging to prevailing ways of working. It has been noted elsewhere that introducing alternative ways of working that run contrary to conventional (medicalised) knowledge, and presumably those based in psychology and in the case of the training, using some psychology-centric terminology, may not result in immediate uptake (Aherne et al., 2019). 'Formulation' itself is often perceived as an inaccessible term and the SUAG discouraged its use as much as possible in participant-facing material, advising its replacement with a description instead.

Despite the perception of the training perhaps being too much too soon to be applied, there was an expressed appreciation in participating in the training and research overall in terms of exposure to theory. The context in which the research took place and the attendant changes to the design meant the training as well as discussions around the implementation of the PNM were highly collaborative. I discussed the Model with the participants in some depth, explaining its origins and conveying the ability for the Model to support current practices as well as address areas they felt could be improved in regard to psychological understanding and the improvement of relationships between staff and service users through enhanced communication. As Brandon indicated: "I think taking part was really good. I think it's beneficial the team sees something in development and get the working background, if you see what I mean. And have the opportunity [to be introduced to formulation]."

Although the overall indication that the training was not generally viewed seriously, one staff member did indicate they intended to apply it to their practice:

> Um, I'm looking at possibly using this with some of our new patients. […] Um, but I-there's so much to do when they come on the ward, it's a lot. [….] I can imagine

> doing all that. That's been in the back of my mind. Thinking a lot about this a little […] It's definitely there. […] I've thought about it. (Luis)

The participant mentioning competing priorities and feeling overwhelmed by existing and mandatory paperwork was echoed by another participants as barriers to the implementation of the PNM within the ward as routine duties leave little room for anything else. For example, according to Brandon, "I suppose thinking about it, really, because we've got [laughs] quite a range of paperwork we've got to do already."

This feeling of overwork and having limited time for else but strict professional requirements and the essential running of the ward is commonly observed amongst NHS staff.

8.3.2.2 Building On and Supporting Current Practices. In the training, it was decided beforehand to emphasise that the Model was intended to support existing practice as far as possible, to acknowledge where things already worked well but also to suggest ways to support and enhance practice. The former was particularly important, so as not to come across as suggesting current practices were not functioning, and it was important to align with the ward's existing treatment model, DBT, which staff indicated they were happy with. For example, according to Sydney, "I like it that DBT's very problem-solving, sort of-okay, we've just got to move on. But I think some [pause] some individuals are fine with that."

It was equally important to identify current practices that bore a resemblance to the PNM to provide scaffolding for an understanding of how it may function in the daily running of the ward: Sydney: "And that's how-that's how I sort of take formulation like that before that. […] And I-I think […]" Brandon: "I suppose the closest we get to case formulation would be clinical discussion." Sydney: "Was literally just thinking that."

Again, the topic of risk was raised, this time relating to the potential for supporting staff to think about risk. Supporting staff in this is particularly important given Poppy ward's PRT orientation in the context of a specialist ward for service users with a diagnosis of BPD. Individuals with this diagnosis may have a history or tendency to cope using self-harm (Gunderson, 2009), which in the eyes of the NHS, makes them 'higher risk' as staff decision-making around self-harm may lead to a higher level of perceived culpability should there be serious injury or other consequences of self-harming behaviour. As one participant indicated:

> And that bit for me – I wouldn't mind thinking ultimately, you know, one for this area; one of these fears that people have with clients who are very risky; you can then use in a kind of-to help think about moving forward. Like you know, maybe what is this person's risk likely to be or how do you protect from future-because in a way this being really valuable because it tells you enough to feel confident in how we're working with that individual because you've sat down, you've done, you know. When-when someone engages in it with you, then […] you know, when it comes back, it's all about, 'did I predict it?' (Sydney)

There was a suggestion the PNM could potentially assist to support PRT by bolstering staff understanding of service users and thereby feeling more comfortable with decision-making.

> Sydney: "Formulating is done and this is how you'd use it. So yeah, it's that kind of power: we use it to help working with this type of client group; how can it make us feel more confident taking such big risks and that kind of thing. […]I think, um, if we could use it in that way, I think that would be really helpful –"
> Brandon: "Mhm."
> Sydney: "To start, because, you know, one of the biggest difficulties in this is that positive risk-taking and confidence thing: feeling confident in it. […] And so I'd need to be showing the thought that's gone into it and that could potentially be really helpful."
> Brandon: "And I think it takes some of the guess work out of it."
> Sydney: "Yeah, exactly."
> Brandon: "Isn't it? So if you've got a difficult –"
> Sydney: "Yeah."
> Brandon: "Person to potential litigation which is any time […] It would take some of the guess work out of-you feel like you're guessing any time you do a risk-assessment […] Effectively you are, aren't you?"
> Sydney: "But it helps a little bit if you've got a document saying this is the pattern; these are the behaviours […] This is what we see regularly."
> Brandon: "And in this situation that then frees the service-user […]"
> Sydney: "Yeah."

As Sydney indicated, PRT may be a difficult practice in context despite it being advocated within the ward. The ward exists within a wider organizational culture of risk-averseness and constantly being exposed to potential litigation, as stated by Brandon; PRT exposes staff to additional scrutiny and potential legal or other unfavourable consequences (Robertson & Collinson, 2001). The PNM could possibly benefit staff by creating more clarity and understanding of why particular decisions could help or harm a service user. This discussion highlights that PRT involves considering the risk posed to both service users and staff and that within the current climate of risk-averseness, staff require support to feel safer and more comfortable in riskier decision-making.

8.3.2.3 The Importance of Being Accessible. Staff discussed the importance of practices such as the PNM being accessible: something all staff could be comfortable doing and contributing to. For staff who participated in the focus group, this was seen as necessary for the formulation process.

> Brandon: "I think for it to work, the whole team would need to be aware, wouldn't they?"
> Researcher: "Right."
> Brandon: "For it to function and be effective."
> Sydney: "I think-like [Alexis], I think when you're on a weekend and you're out with an individual, you could get information that none of us get on a weekly basis-you could get–"
> Alexis: "Yeah, you spend more time with them."
> Sydney: "You know, people talk to you probably about things they wouldn't talk to anyone else about and you would have so much-particularly about the meaning thing; I think, you know, everyone would, I think, bring useful information to –"
> Alexis: "Yeah."
> Sydney: "Something like this."
> Alexis: "Yeah, when you're with someone for a longer period of time, things just come out without them even meaning to say it [general group murmuring in agreement]."
> Alexis: "So I guess if you knew about that, then yeah. It would be good if everyone kind of had a little bit of input."
> Sydney: "Mm."
> Alexis: "And then it was all put together."

One staff member suggested the usefulness of similar group discussion frameworks, such as Historical Clinical and Risk Management (HCR-20; Douglas & Reeves, 2010), in which all staff contribute, suggesting the PNM could operate in a functionally similar way.

> Situation, yeah, we can bring it all down to situation. Um, but it's a-it's everyone does it together; it's a big group discussion and everyone puts their stuff in and that would be, um, it would be useful to do. And-and-and I feel like we-I think it would be […] on assignment something that would be useful. […] Us to create something like that for the future [pause] […] Yeah, but just would be nice to, 'this guides our case discussion quite nicely. (Sydney)

There was a shared feeling that all members of the MDT, given their individual experiences, professional background, and relationship with service users, have something of value to contribute to a formulation and therefore all should be supported to attend. This support should possibly extend to training on formulation, not just in terms of familiarisation

with the process, but with confidence possibly being key given there is evidence showing that even for novice clinicians, who have ostensibly been taught formulation principles, reported confidence levels are low (Kendjelic & Eells, 2007).

> Sydney: "Definitely been-I wasn't at the training-but there is a space to create formulations within DBT and people have been quite, um, sort of apprehensive about doing it. I think there just isn't that-just that experience of doing a formulation and viewing a formulation. […] It sounds very, um […] You know, it's a very psychological term, so […] So, whereas actually, I think everyone has the skills to do their formulation, to […] complete a formulation, so just I guess a-um, a lot of guidance, I guess, isn't it? […] In the beginning, just to get confident doing it and know they're doing the right thing and the information they're gathering and just being right and confident in their own, because –"
> Brandon: "Yeah."
> Sydney: "Sometimes there's not that much confidence in then-you know, we often hear, you know, you can see the information on RIO. But it's not about just the facts, it's about what are you taking from that and what is your professional opinion. Um, I'm not sure we're encouraged to do that, you know."

8.3.3 PNM could Add Narrative, Meaning and Coherence

One of the themes developed regarding a potential benefit of PNM was that it could add meaning and coherence to practices on the ward. One area staff suggested does not currently reflect their standards when it comes to person-centred practices was care-planning.

8.3.3.1 Care-Planning Feels Divorced from Other Practices. There was a suggestion the current care-planning process seemed to be divorced from other practices. One staff member suggested this may be a common experience across inpatient wards.

> Madison: "I do remember asking in a meeting once [at another ward], whether patients ought to be considered in preparation for their ward round, if the meeting ward round—"
> Brandon: "Yeah."
> Madison: "Should be considered in care-planning and the progress they're making. Everyone looked at me as if I were completely off my head. [someone laughs] And not just patients, the staff as well."
> Brandon: "Mm."
> Madison: "And it seems to be completely divorced from [practice]. […] There must be obligations, right, they don't really guide our days. Not in our case."
> Brandon. "No."
> Madison: "I mean, I'd likely know what's in most people's care plans, but they're all quite similar. Um, but they don't really guide the work that we're doing."

Participants' expressed feelings of frustration at what are viewed as bureaucratic procedures, including the care-planning process, align with the themes identified in Chapter 5. One participant suggested the care-planning process is so unrepresentative of their usual work that they feel ashamed to share them with other teams.

> Sydney: "I get really-when another organization asks for a copy of a care plan, and there's like, this is not doing us any justice, this copy […] it's-it tells you nothing about-of value about the individual and I-I hate sending-I hate forwarding it to a, you know, community, social work whatever, I find it embarrassing. I just think it-it's –"
> Brandon: "Yeah."
> Sydney: "Maybe they're useful, you know, and the risk-assessment again, it's not-we don't have-it's not […] anything to do with the purpose of filling it-it's a way of […] it's not –"
> Madison: "And they feel comfortable […]. Patients will come to ward rounds and say, you know, I want this […] and I think, that's not even mentioned in your care plan. [murmurs of agreement] So why are even they not making the connection between what they're trying to achieve while they're on the ward and –"
> Brandon: "Mm."
> Madison: "The care plan [laughs] there seems to be a complete [pause]"
> Sydney: "Mm."
> Madison: "Separation."

Interestingly, these feelings of doubt and frustration regarding the quality of care plans were largely unshared by the service users interviewed at an earlier phase of this research, who seemed to find fault with care-planning infrequency, not its quality. This is perhaps evidence towards the 'dodo bird verdict' (Budd & Hughes, 2009), the argument that it is the common features between treatment modalities or practices that effect recovery or improvement in service users, as opposed to the particular effect (specific factors) of any one model or theory (e.g., CBT, DBT, etc.). Arguably, the therapeutic relationship, empathy, and warmth (Lambert & Barley, 2001) are responsible for service user satisfaction while a misalignment with the care-planning process on the part of staff leads to a less favourable attitude towards it.

The care-planning process was viewed by staff as an impersonal process and not directly helpful to service users. Brooke: "Mm, yeah, myself doing care-planning – to see how that's helpful to the staff or the patient." Brandon: "Mm." Brooke: "It's literally just a-a tick box of just writing."

8.3.3.2 PNM Could be Helpful with Care-Planning. This frustration at what are viewed as a 'tick box' exercises was thought to provide an opportunity for the PNM to add value to the care-planning process. By marrying the two by aligning their aims, the PNM would more likely to be prioritised because it would result in the required care plan, but would hopefully be a richer, more helpful document as the PNM would promote a deeper understanding of the service user and their needs. According to Brandon: "Perhaps in teaching it can be looked at how… we, there's a method potentially of building care planning in formulation."

Despite the potential benefit of including the care-planning process within the PNM, there was a concern that this might, in effect, erode the impact of the PNM and its intent to introduce an alternative, more psychosocial and political ways of understanding distress.

> There's a tendency to co-opt things, isn't there, into current models. So formulation, the formulation language to fall out and perhaps not achieve its full potential, if you see what I mean? […] So perhaps another form of care-planning rather than a formulation. (Brandon)

Concern over the potential for the de-radicalisation and sanitisation of more challenging ideas within a wider dominant culture is likely reasonable. Researchers have noted this happening (Beresford & Russo, 2016), and is perhaps an expected reaction given existing theories related to threat reactions.

Another potential benefit of the PNM relating to its potential to enhance the care-planning process was thought to be the increased opportunity to work collaboratively with service users, involving them in their care.

> As an organization, we're expected to be done [care-plans] […] In a very, very short time, isn't it? […] And perhaps focusing on this as a model that produces benefits over time […] Um, in terms of that as well, you can extend it to further engagement with the service-users, isn't it? (Brandon)

Brandon also suggested the increased contact with service users by way of the routine practice of discussing their PNM could, in effect, encourage increased openness: for service users to reveal their whole selves, which in earlier phases of interviews with staff indicated is not always the case, even by the end of the one-year treatment.

> I wonder if opportunities to discuss that might improve that, though. I think a lot of the opportunities for some patients is just to circumnavigate and avoid […] Some

> major sessions […]. Um, and I'm not saying to force them to sit down to write it […] But […] develop those lines and […] we might get some of the patients that as well, more engaged with it. (Brandon)

8.3.3.3 Meaning and Narrative Could Be Helpful Additions. The major benefit of the PNM was thought to be one of its main aims: ensuring personal meaning and narrative are represented and considered in the course of service users' care. There is an increasing awareness that although a high proportion of service users, particularly inpatient service users, have a history of abuse or trauma (Muskett, 2014), they are rarely asked about their history. One participant indicated that opening this conversation is much needed:

> Um, I imagine there's loads of patients who sit on a story wanting to say that, tell that [general noises of agreement] permission, even. […] To do so within services. So I wonder if it would provide permission to tell their […] Their story. (Brandon)

Although it was acknowledged that DBT as the main treatment within the ward offers an approach many find helpful, there was a feeling that some service users could benefit from the addition of an exploration of previous experiences and a deeper understanding of their trajectory:

> Sydney: "I like it that DBT's very problem-solving, sort of-okay, we've just got to move on. But I think some… some individuals are fine with that, but I think some people feel, um, a bit like, well I-I need to think about this. I need to think about my past as well and it is-um, yeah, I can see that-I can see it being helpful to think through it. And it's quite empowering, isn't it? Of course I'm where I am, because of this." [Gestures to PNM handout.]
> Brandon: "And it be-so one of the things DBT does is-it doesn't really give the power to the individual at the end of therapy, at the start, or midway through. If there's a way of doing that, I don't know."
> Madison: "Being able to recognise and recognise and bring that again."
> Sydney: "Mm."
> Madison: "You know, because it's really helpful […]. I think of it all the time. We all do it, don't we? It's the record we put on automatically to challenge in order to not to everything that we've done."

8.3.3.4 DBT Formulation is Limited. While on the whole, staff reported positive regard for DBT, the focus of DBT on the present and future was thought to sometimes impede progress by obscuring the reasons behind a person's reactions to the events of their lives, how they dealt with them, and their current position. As Sydney indicated, having reasons for how a person came to be may be empowering, and goes beyond the tautological explanation provided by, for example, diagnosis.

> Sydney: "Because DBT it's more about moving forward, isn't it? Whereas this, you know, looking back and thinking about why, um, which can be very helpful, can't it?"
> Brandon: "Yeah."
> Sydney: "You know, to look back at your past, what led you to get to this point."
> Brandon: "Yeah, the patients expect it, don't they, I think? Some of them are quite struck by DBT saying it's today forward."
> Madison: "They're not really sure what they-how their personal narrative has come about, and I think that's a problem."
> Sydney: "Mhm."
> Madison: "And therefore, because of that, they don't have a good understanding of their past […] from that problem behaviour. And we could work from here and move forward, but I think sometimes it's about letting them know about."
> [indistinct, Brandon also speaking]
> Madison: "Letting them know that you're constantly thinking that you're no good and you're not part of the group or whatever –"
> Brandon: "Yeah."
> Madison: "If they're not aware of that."
> Brandon: "Yeah."
> Madison: "Make them aware of that. Because they could find it useful, couldn't they?"
> Sydney: "Mm."
> Brandon: "I think DBT glosses over personal narrative, doesn't it?"
> Madison: "Yeah, definitely."
> Brandon: "I think narrative's really important for the person understanding why they are where they are, isn't it?"

One member of staff articulated the difficulty participants in the staff training anticipated regarding service users being asked to recall historical events in their lives; however, this was viewed as a necessary process. Although the 'need' to explore historical traumas is debated in the literature and by clinicians, no doubt the option to do so would be valuable to those service users wish it.

> It's quite [difficult to] make it more personal, whereas this one, I can see-see it being quite difficult for the patient initially, but I think as kind of a new member of staff, you've got to look at the past, how you've turned up the way you are now as well as

> working extra, extra hard to improve the future. […] So, and, um, looking at the Model, I think that look quite clear. […] I think that looks quite-quite nice. (Brooke)

The emphasis on meaning was predicted to be helpful to keep in mind when working with service users. Some staff indicated they may already be working this way, particularly when focusing not on particular historical events in service users' lives but instead on how this affected them and the messages they internalised about the world, themselves, and others. As the value of the PNM for this particular ward was to acknowledge and support the practices staff are satisfied with and align with a more recovery-focussed agenda, this was a heartening comment.

> Madison: "In DBT one-to-one we do the planner, don't we? [Murmur of agreement]
> Brandon: […] and we don't really spend time thinking about [pause] this bit [indicating to handout of PNM] how we [understand the service user] [murmurs of agreement] So the meaning they've got out of it, what they've taken from it."
> Sydney: "The meaning and the-the effect, yeah. So I like that that box is, you know, in the side-line."
> Madison: "Mm."
> Sydney: "It's not so much about past experiences, it's not necessarily about what you want to know, it's just about the meaning that you've taken –"
> Brandon: "Mm."
> Sydney: "From past experiences, that's what-that's what's important. Um."
> Madison: "Yeah, because I don't particularly-I-I just naturally think I talk to people like that, like you've told me past things have happened."
> Sydney and Brandon: "Mm."
> Madison: "So this is how you feel about yourself; this is so, can you […] your belief in this situation is that you need to challenge them because you said yourself that you're waiting."
> Sydney: "Yeah, it's just that –"
> Madison: "As a prompt or reminder of that whole dialogue."
> Sydney: "Yeah, we all kind of do it."
> Madison: "Yeah […] One of the interesting things is it's the same [thing] I'm just thinking that this paper kind of […] things like meaning of those. How it affects them."

8.3.4 The Proof of the Pudding Is In the Eating

Participants indicated that to fully align themselves with the PNM and be willing to implement it within everyday practice, they needed to observe its efficacy; to introduce it to service users and get their impressions; and for there to be concrete plans in place to ensure all staff were familiar and comfortable with its application.

As stated by Sydney:

> Yeah, I just think it would all just be important once we've done it, once we're doing it. People are more likely to do it if they see the value […] See how it's being used and why it's helpful. (Sydney)

8.3.4.1 Benefits over Time. There was an acknowledgement the PNM may need to be developed over a long period of time to ensure adequate information gathering.

> Sydney: "I think it's something I think-like you were saying, Brandon-it would have to be something to not have too short a time limit on."
> Brandon: "Yeah."
> Sydney: "Information to gather over a period of time. If you think, you know, some of the outcome measures that we do-I know I-I think my ones are not very informed because I just know I've got to do them within X amount of time. Whereas, you know, you know, it could actually take six months to-to gather effectively. […] Thinking about what [we] ought to have done by."

Staff reported there would be a need to market the PNM as a process that does not deliver quick results, particularly in the context of the NHS, where timely services and results are the benchmark. As stated by Brandon, "As an organization, we're expected to be done in [..] In a very, very short time, isn't it? […] And perhaps focusing on this as a model that produces benefits over time [would help]."

8.3.4.2 Multimodal Implementation Required. Participants felt they required an array of methods to support their learning of the PNM and its principles. This was described as learning styles by one participant:

> Luis: "It depends on people's learning styles. [group agreement, Brandon in particular] […] Because I'm aware that for me, in theory I can read it, but when it comes to actually applying it, I learn better through doing."
> Sydney: "Doing, yeah."
> Luis: "So I think that on-the-fly would be better rather an intensive [approach].

Brandon reinforced this again later in the discussion: "It's like what [Luis] said, it's down to individual learning style […] Isn't it? I love a presentation and a video […] And some people don't and don't learn from that well."

Observation and shadowing were also thought to be helpful in receiving immediate feedback and bolstering confidence.

> Madison: "I think not just-shadowing would be helpful, but I think I-I'd like more of a chance because I think […] when I have my first one, I'd have to –"

> Brandon: "Mm."
> Madison: "To be there, to just observe and to help me if I get stuck or if I have-help me if I [need it]."

8.3.4.3 Ongoing Support and Maintenance. Ongoing support was also viewed as necessary, whether this could take the form of experts based on the ward who could ensure fidelity to the PNM and its main messages as well as ensure the whole team received the training on its use:

> Sydney: "You might need people who are particularly well versed in it [the PNM]–"
> Brandon: "Mm."
> Sydney: "Who can then catch people who-people that, like, guide and be around, you could-you could kind of be here for six months and not get everyone."

Besides PNM subject experts, the provision of supervision was also predicted to be helpful in bolstering staff confidence in their abilities to use the PNM. Stated by Brandon: "So I think that's actually a really valid point that supervision and supports really." Researcher: "Mhm." Brandon: "And the confidence just to be able to do it, isn't it, really?"

8.4 Discussion

The third research aim directed this phase of the research to explore the acceptability of the PNM in a specialist inpatient context. The fourth question is addressed.

4. What are specialist inpatient staff views of the PNM and its acceptability? What are the enablers and barriers?

Many of the barriers to the Model having a meaningful impact on everyday practices appeared to be logistics: the difficulty for staff to attend the training was expressed to be a major barrier. Given the applied and small-scale nature of this research, this particular barrier was to be expected, particularly compared to a study by Leamy and colleagues (2014), whose research on the implementation of a complex intervention to support recovery entailed a much larger-scale and resource intensive intervention and still was largely met with resistance. Leamy and colleagues thus (2014) suggested future research first measure organisational readiness for change to evaluate the success of implementing complex interventions. In this research, focus group participants did not indicate resistance to the PNM on principle; rather, they offered solutions and suggested the resources required to effectively

embed the PNM, as described in the theme 'The proof of the pudding is in the eating.' For example, staff indicated a gradual process of demonstrating the benefits of the PNM over time; offering more comprehensive and wide-spread training; as well as ongoing support and assistance to effectively support its use. Thus, resources and organisational willingness to change are likely factors amongst those required for successful implementation.

Bolstering findings from Chapter 5, staff voiced the possibility for the PNM to add value to the care-planning process as well as add meaning and coherence where the DBT approach does not. Staff were careful to emphasise that DBT with its focus on the present is helpful for many service users as-is and that not all service users may wish to explore their experiences through a narrative lens or explore past experiences, nor would this be clinically warranted or desirable. In their expressed apprehensions regarding the potential risks of introducing the PNM to service users, there is some evidence that staff were likely justified in their concern that working with a service user on the PNM could introduce trauma, not just given the historical events Sydney anticipated, but the very process of developing a narrative. Robertson and colleagues (2020) cautioned the development of narrative may be emotionally difficult and advise for its practice to take place within an emotionally supportive environment. Thus, potential implementation of the PNM would likely require additional steps to emphasise emotional support and validation. Despite the risks introduced by a narrative approach and its possible undesirability for some service users, staff indicated a subset of service users would benefit from the option to explore their past using a narrative approach, whether this is achieved using the PNM or not.

It is interesting that a significant proportion of the apprehension expressed by staff relates to their own comfort in discussing past events or trauma with service users. This attitude may somewhat explain the reports of service users not being asked about what has happened to them in services, or not being 'heard' when this is disclosed (Sweeney & Taggart, 2018). It may also explain why, when they are asked, an acknowledgement of the impact of these past events does not inform the broader treatment approach (Sweeney & Taggart, 2018). Discomfort in addressing trauma, as indicated in the findings, may be explained by an engrained aversion to risk within the NHS (Millar, 1998).

Similarly, the finding of risk being mentioned in relatively risk-averse ways, particularly surrounding the risk of re-traumatising service users by asking about their histories (as above) as well as discussion surrounding 'risky patients' in a ward advocating for PRT and other recovery-oriented practices was surprising. Again, somewhat paradoxical to a PRT approach, there was a suggestion the PNM could be employed to assist with

bolstering the accuracy of risk assessment, an interest that suggests support for Repper and Perkins (2003), claiming that a 'blame culture' has led to a level of defensiveness in mental health practice and the need to "cover one's back." The authors critique the result of this phenomenon in that it leads to a perception of professional proficiency is judged according to one's ability to predict risk; however, as stated by Repper and Perkins (2003), the very nature of risk is that it is unpredictable.

This study's finding of staff dissatisfaction with the care-planning process aligns with those expressed by the senior members of staff described in Chapter 5 but oppose those expressed by service users in Chapter 6. Within the present focus group study, staff indicate a disconnect between existing care plans and service users' expressed preferences, which aligns with existing research (Sainsbury Centre for Mental Health, 1998); the noted substandard relevance of care-planning in mental health has been linked to the rampant bureaucracy, paperwork, and overburdening of staff time and resources was made by Drummond and Simpson (2017) and links with findings from the present study's findings with staff reporting being at capacity in regards to paperwork and other duties.
That staff perceive within their current practices a decontextualised and unhelpful care-planning process while service users report finding it helpful is one not previously reported in the literature, to my knowledge. One possible explanation is that staff require a coherent theoretical framework to guide and structure their practice (Isobel & Edwards, 2017) and while DBT serves this purpose on the whole, the disjoint between the (bureaucratic checklist-guided) care-planning process and other ward practices creates tension that leaves staff frustrated. That this was fleshed out more fully in the context of a focus group is interesting and supports the methodological choice to employ a focus group in comparing perspectives and generating ideas (Tickle & Braham, 2012).

One finding regarding a possible implementation method for the PNM was around the importance of whole-team involvement. There is evidence of MDT members finding formulation helpful for their practice (McTiernan et al., 2020) and an egalitarian view of whose voices matter aligns with the findings from Chapters 5 and 6. There was evidence of this orientation existing within the focus group, as more senior members of staff made an effort to engage and include HCAs (for example, Ariel did not participate in the focus group until directly asked for her opinion by other focus group participants). Ensuring all staff members, including those of 'unqualified' status, both bolsters a sense of community and belonging, but also adds depth and comprehensiveness to discussions as, as discussed in

Chapter 5, HCAs spend the majority of their time speaking to service users and therefore may be privy to information not disclosed to other staff members.

The importance of whole-team involvement necessitates a discussion regarding 'meeting staff where they are at,' particularly regarding the importance of the PNM being accessible. To meaningfully include all members of the MDT, psychological formulation should be de-mystified, its objectives and function explained clearly and using clear language. While this was attempted in the training, particularly following the feedback from the psychiatrist who attended the first session, this was difficult to accomplish in the disjointed sessions staff were able to attend.

9. Chapter 9 Online PNM Acceptability

9.1 Chapter Overview

For this phase of the research, I was interested in the perspectives of mental health practitioners as well as individuals with lived experience. Input from the former was particularly important given it was not possible to implement the PNM with service users in earlier phases of the research and thus their views were yet untested.

The aim of this phase was 4) to explore the wider acceptability of the PNM and solicit suggestions for its implementation, including any suggested improvements. Both acceptability as well as suggested future implementation were hoped to be explored. For the purpose of this research, the distinction between the two is that acceptability, as defined within this research, is "a multi-faceted construct that reflects the extent to which people delivering or receiving a healthcare intervention consider it to be appropriate, based on anticipated or experiential cognitive and emotional responses to the intervention," (Sekhon et al., 2018, p. 4) and proposed implementation relates to the actual process or factors involved in introducing or embedding the PNM. In other words, acceptability was conceived of as factors related to the Model itself while potential implementation related to its interaction with proposed users and their contexts or environments. Most major aspects can be distinguished on this basis, although a degree of overlap exists.

In this work, the following research question is addressed:

5. What are wider stakeholder (clinicians and/or individuals with lived experience of mental health difficulties) views of the PNM and its acceptability? What are the enablers and barriers?

9.2 Methods

9.2.1 Rationale for Research Methods

The rationale for using a mixed-methods qualitative and quantitative survey alongside semi-structured interviews is described in full in Chapter 3.

9.2.2 Procedure

Qualitative and quantitative data were collected via Qualtrics, a platform used for online survey research. The Qualtrics site included the participant information sheet and

consent procedure, which were embedded within the webpage (see Appendix H). Agreement to the terms were required before taking part in the study proper.

The Qualtrics survey was divided into two sections. The first section was the same for all participants and involved viewing a 15-minute video explaining the PNM and responding to questions about it (e.g., is it similar/different to your views of mental health). The second section varied for participants who identified as having lived experience; they responded to questions relating to their wider experiences of services or care. Practitioner participants viewed a 10-minute video explaining the results of the Poppy ward research and responded to questions about it (e.g., how the results relate to their own experiences of services).

Participants who took part in the Qualtrics survey then indicated their availability in Qualtrics and provided contact details to arrange participation in a further interview or focus group (their choice of which). Due to low numbers, only interviews were able to be offered.

9.2.3 Survey

Quantitative and qualitative data were collected from 26 participants (15 participants with lived experience and 11 mental health practitioners).

The first part of the survey involved viewing a video explaining the PNM (see Appendix H) which was responded to by all participants who then responded to a series of Likert-style and open-box questions that related to acceptability. A nine-item modified version of the Treatment Evaluation Inventory (TEI; Landreville & Guerette, 1998) was used to evaluate acceptability.

The next part of the survey asked questions related to implementation, although the focus of the questions was different for practitioner and lived experience participants. For practitioner participants, this included viewing a video relating to the implementation of the PNM at Poppy (see Appendix H) and answering a series of related Likert and open-box questions. Participants with lived experience answered a series of Likert and open-box questions related to past experiences with services. All questions were developed in reference to the overarching research questions and surrounding literature.

9.2.4 Semi-Structured Interviews

Eight interviews were conducted with participants who had indicated their interest within the survey, with four individuals with lived experience and four practitioners. The

length of interviews ranged from 7 minutes (the remainder of the interview failed to record properly) to an hour.

Participants were interviewed using Microsoft Teams, the Anglia Ruskin University-approved video-messaging platform. Interviews were digitally recorded for transcription.

9.2.5 Participants

Invited to participate were both mental health practitioners with experience of working therapeutically one-to-one with service users and/or individuals who had used mental health services (in whatever capacity). The third category of 'practitioner with lived experience' was included as "categories of 'service user' and 'mental health professional' frequently overlap" (Spandler & McKeown, 2017), although for pragmatic reasons relating to analysing the data, participants who indicated they were practitioners with lived experience underwent the practitioner question pathway.

The inclusion criteria were that participants were over the age of 18 and English-speaking as well as being based in the UK. Participants were given the option to enter a prize draw to win one of two £50 Amazon gift vouchers.

Due to difficulties with recruitment, an amendment to the recruitment strategy was sought and approved to accommodate Anglia Ruskin students more clearly with experience working one-on-one with service users, including those with professional experience of 'unqualified' roles, part-time work, or placement experience. Anglia Ruskin University Psychology undergraduate students were additionally awarded credits as part of the research participation scheme.

9.2.6 Recruitment

10.2.6.1 Mental Health Practitioners. I used a convenience sampling technique combined with a snowballing sampling method. Thus, contacts known to me were approached with information about the study and a Qualtrics link to participate.

Recruitment advertisements were also posted on social media (e.g., Twitter). Members of my supervisory team distributed details related to the study to their respective networks.

9.2.6.2 Individuals With Lived Experience. Like the recruitment strategy for recruiting mental health practitioners, I used a convenience sampling technique combined with a snowballing sampling method for the recruitment of individuals who had used mental health services.

In parallel with practitioner recruitment, the link to the Qualtrics site which directed participants to the participant information sheet and consent procedure. Agreement to the terms were required before taking part in the study proper. Individuals with experience of mental health difficulties who took part in the first phase then indicated their availability in Qualtrics and provided contact details to arrange participation in a further interview or focus group.

9.2.7 Ethical Considerations

This study received the School Research Ethics Panel (SREP; EHPGR-28) and was ratified by the Faculty Research Ethics Panel under the terms of Anglia Ruskin University's Policy and Code of Practice for the Conduct of Research with Human Participants. Chapter 3 describes the general ethical approach taken throughout this research. This section describes details particular to this phase.

A convenience sampling and snowball recruitment technique introduced the risk that our existing relationship may influence their responses in the case that participants known to me took part in the research. I therefore took the following actions to counteract this risk: (a) interview schedules avoided leading questions; (b) participants were assured their answers did not affect our relationship, and (c) that participation was voluntary, and that withdrawal would not affect my opinion of them. Participants were assigned pseudonyms to ensure their anonymity.

9.2.8 Transcription of Interview Data

Transcription protocol followed that described in Chapters 5, 6, and 8.

9.2.9 Strategy for Data Analysis

As described, qualitative and quantitative data were collected concurrently. Three datasets were involved in this research: qualitative survey data; quantitative survey data and qualitative interview data. Qualitative and quantitative data were analysed separately and combined at the point of analysis. The two qualitative data sets (interviews and qualitative

survey results) were treated as a single corpus. One duplicate participant was detected; their qualitative responses were combined. Quantitative scores were also combined and where scores diverged, the more fault-finding score was used.

9.2.9.1 Qualitative Data. Qualitative survey data were downloaded from Qualtrics then transferred to NVivo 12 alongside the anonymised interview data. The strategy for data analysis aligns with that described in Section 5.3.5.

9.2.9.2 Quantitative Data. Quantitative survey data were downloaded from Qualtrics, then transferred to SPSS for analysis. Frequencies and percentages are reported alongside mean and standard deviation. Quantitative data relating to implementation were collected only from participants with lived experience.

As described, the research questions ask two distinct questions relating to acceptability and implementation and the findings have been separated accordingly.

9.2.10 Demographics

The sample was comprised of 16 (61.5%) individuals aged 18-25; nine (34.6%) aged 25-49; and one (3.8%) 65+ years old. Three males, 22 females, and one who identified as non-binary participated. Seven practitioners, five practitioners with lived experience, and 14 individuals with lived experience took part. One participant who identified as a practitioner with lived experience did not complete the remaining demographic questions.

9.2.10.1 Staff Participants. Five participants indicated they practice in the East of England, three in the South East, and one each in London and the West Midlands. One preferred not to say. Staff participants' place of employment included two private practice; five NHS; and three third sector settings. One preferred not to say. Participants' work settings included one 'prefer not to say,' six community mental health services (one recovery and outpatient setting, one personality service, and one community support); one supported living, one care home and one in a carer capacity. Staff spent a range of 0 to 10 years training, for an average of 4.59 years. Years spent in current role ranged from 0 to 10 years for an average of 4.15 years.

9.2.10.2 Lived Experience Participants. Five participants with lived experience indicated they had received services in the East of England; two each reported receipt of services in the South East, South West, and London. Three preferred not to say. One received services in the East Midlands. Eight participants preferred not to say the type of support they had received. Of those who responded, many spanned multiple services. One each indicated adult mental health services; adult community mental health services; Improving Access to Psychological Therapies Service (IAPT), MIND counselling; NHS mental health assessments and therapy services; perinatal services; IESO (Digital Mental Health); psychiatrists, therapists, counsellors, and psychologists. Three indicated they had received services from Child and Adolescent Mental Health Services (CAMHS). Participants' duration of mental health difficulties ranged from 6 months to lifelong. Two participants indicated they had experienced difficulties for 6 months, and one for three years. Eight participants indicated they had experienced difficulties for five or more years while four preferred not to say. Four participants indicate they were currently undergoing treatment from mental health services while 11 were not.

9.2.11 Procedures for Assessing the Quality of the Analysis

The same procedures to ensure quality described in Chapters 5, 6, and 8 were taken here.

9.3 Results: Acceptability Mixed-Methods Analysis

9.3.1 Acceptability: Quantitative Data.

See Table 9.1 for a summary of the acceptability descriptive statistics.

Table 9.1

Descriptive Statistics for the Acceptability Measure (Modified TEI-SF)

Scale	*M*	*SD*	Observed Range of Scores	Possible Range of Scores	Cronbach's alpha (α)
General acceptability	9.73	2.442	6-15	6-42	.661
Negative aspects	8.12	2.732	4-14	3-21	.605
Global	17.85	3.781	12-25	9-63	.563

Note. Higher numbers indicate higher acceptability.

The full set of responses to the acceptability scale can be found in Appendix G; to illustrate, a subset of questions and responses are described here.

To the question 'How acceptable would you find the PNM to help treat mental health distress?' 12 (100%) of practitioners indicated 'very acceptable' or 'acceptable' while 14 (100%) of those with lived experience indicated 'very acceptable' or 'acceptable.'

To the question, 'How effective do you think the PNM is likely to be?' 12 (100%) of practitioners indicated 'very effective or 'somewhat effective' and 14 (100%) of those with lived experience responded the same.

To the question, "overall, what is your general reaction to the PNM?" 12 (91.7%) practitioner participants responded, 'very positive' or 'positive' while 85.7% of lived experience service user participants responded, 'very positive' or 'positive.' One practitioner and one lived experience participants responded, 'slightly positive' while one more lived experience participant responded, 'ambivalent.'

Items that formed the 'negative valence' subscale demonstrate negative ramifications likely predicted to result from the PNM. To illustrate, the results from the question relating to risk are reported here. To the question, "to what extent do you think there might be risks in undergoing the PNM?" five (41.7%) practitioners responded, 'no risks are likely' or 'risks are not very likely' while four (33.3%) responded 'some risks are likely,' two (16.7%) responded 'risks are slightly likely' and one (8.3%) responded 'risks are likely.'

This can be compared to six (42.9%) of service user participants responded, 'risks are not very likely,' 'four (28.6%) responding 'risks are slightly unlikely,' three (21.4%) responding 'some risks are likely' and one (7.1%) of participants responding that 'risks are slightly likely.'

To contextualise participant impressions of the PNM, additional questions relating to acceptability were asked, including "Is the PNM different from how you currently think about mental health?" to which six (50%) of practitioners responded, 'not at all,' four (33.3%) responded 'somewhat' and two (16.6%) responded, 'Reasonably' or 'Mostly' while five (35.7%) of participants with lived experience responded 'Not at all,' seven (50%) responded 'somewhat' and two (14.3%) responded 'Mostly.'

Practitioner participants alone were asked the last two questions relating to acceptability. The first of these questions is, "How relevant do you think the PNM would be in your service?" to which three (25%) of participants responded, 'somewhat,' and six (50%)

responded, ‘very’ with the remainder selecting ‘reasonably’ or ‘mostly.’ To the question, “How confident would you be to use the PNM?” the highest proportion (five; 41.5%) responded ‘very’ while an equal number (two; 16.7%) responded ‘somewhat,’ ‘reasonably,’ and ‘mostly.’

9.3.2 Acceptability: Qualitative Data

Four themes were identified relating to the acceptability of the PNM. These included (a) A warm welcome to alternatives to the biomedical Model, (b) The PNM’s legitimacy, (c) Predicted practical utility of the PNM, and (d) PNM as inclusive but unproven. These themes will be explored in turn (see Table 9.2 for a summary).

Table 9.2

Summary of Online Acceptability Themes

Theme	Subtheme
A Warm Welcome to Alternatives to the Biomedical Model	PNM ‘Very Good’
	Strengths Focus Helpful
	Problems Live Outside of People
	People Cannot be Put in Boxes
The PNM’s Legitimacy	Boosting Trust in PNM
	Compatibility With Current Ways of Working
	Valued Departures From Other Models
	Unhelpful Elements of the Model
Predicted Practical Utility of the PNM	A Compass in Chaos
	PNM Creates Emotional Distance
	Record of progress, Accomplishments to Help with Motivation
	Thorough, Inclusive, Exhaustive
PNM as Inclusive but Unproven	The PNM’s Accessibility
	The PNM Supports Client-Centred Collaboration

Meaning and Identity Possibly Support Cultural Differences Improving Inclusivity

9.3.2.1 A Warm Welcome to Alternatives to Biomedical Model. One of the most prevalent themes featured participants expressing enthusiasm for the PNM's psychosocial focus. This was considering the critique that while biopsychosocial models pervade services, there remains a focus on biological influences and factors that serves to support the biomedical model (Johnstone, 2020).

9.3.2.1.1 PNM 'Very Good.' Of those who responded to the qualitative survey question asking for their thoughts regarding the PNM, all participants wrote favourable responses. Affective attitudes towards PNM were generally positive and typically unreservedly so. The following survey quote from Jane (female, lived experience) demonstrates this: "in principle, it sounds incredibly useful and needed." Echoed by Jessica in her interview, "If I was a nurse and I wanted to improve my patient's wellbeing, I'd be so happy to use it."

However, in her interview, Jessica expressed an initial reaction likely to be common amongst practitioners given the ever-expanding array of models and approaches, "The first thought was, 'oh gosh, yet another model.'" Jessica indicated her opinion changed once the PNM had been explained but it is important to highlight the likelihood of this attitude being pervasive amongst practitioners, particularly in the context of a later comment that she and other NHS staff receive "a lot of emails" about training, indicating a saturation of opportunities for staff, at least for some staff.

Countering this attitude, one interview participant (Jane) who identified as having lived experience expressed appreciation for additional models on offer: "that's what I really like – I really do like it and I think it could offer a lot. […] I think – very nice to have more options. I think there's nothing wrong with having more options."

Although it is not practical (or even possible) for staff to be trained in assortment of therapeutic modalities or approaches, at least to a degree of proficiency and fidelity, offering models such as the PNM that seek to be modality-unspecific and embrace complexity could assist a subset of service users who are not better served by the models otherwise available.

9.3.2.1.2 Strengths Focus Helpful. As an antidote to the deficit focus of the medical model, one of the aims of the PNM was to centre and integrate service users' strengths and resources. This was received enthusiastically by participants. For example, in her survey response, Chloe (female, lived experience) stated, "Focusing on strength aligns with recovery model, giving service users a sense of self, removing labels of illness and top-down care (paternalistic)."

Although strengths-focused models are not new and models such as the '5P' (Johnstone & Dallos, 2014) include positive attributes, it is possible these are not typically implemented within services, as was reported by a portion of participants with lived experience. Participants indicated the application of a positive lens to aspects of their lives not typically viewed this way was likely helpful. For example, both lived experience and practitioner participants indicated they found framing coping responses as positives helpful as well as exploring positive aspects of past experiences and identifying positive meanings to reframe experiences. For example, in a survey response, one practitioner indicated:

> I really liked this idea that the meaning we are looking for is positive and negative. Usually the focus is on the negative outcome of people's past experience, but with this formulation, the focus is on positive meaning, as if I did not experience this I would not be the person I am now, e.g. bullying, negative: "I am a failure" but positive: "it made me stronger to 'fight bullies and protect others from bullies.'" […] I am actually going to introduce this to my client as it's true; it is both meanings. Positive and negative meanings shape who we are and how we behave. (Survey, Jessica, female, practitioner).

Drawbacks of a strengths-based approach were identified, although these formed a subset of responses. One participant indicated focusing on one's strengths or positive aspects is un-British, mirroring concerns expressed by British participants in a study on the acceptability of a positive psychology intervention for depression (Walsh et al., 2018); what the authors called 'cultural fit'. That this was not an overly common theme may indicate the PNM uses more acceptable language or less 'American terminology' as that used in the authors' intervention (e.g., 'gratitude').

> I think there's something as well between – I mean, this may not be helpful, so stop me if not but, um, between Canada and UK and the difference in accepting, um, positive things about yourself. I think it's harder here. I – there's m-there's more of a willingness and openness in Canada to think of yourself in more of a positive light,

> whereas I feel Brits can be quite harsh on themselves (Interview, Ursula, female, lived experience).

Another participant suggested that service users with a diagnosis of BPD may find a strengths-based approach invalidating:

> For some personality disorder clients, the suggestion of any strength is invalidating […] You know, so they tend to resist. It's like, how dare you say that I've got strengths. (Interview, Richard, male, practitioner and lived experience)

Another participant acknowledged the likely difficulty of identifying positive aspects about themselves for some service users (Walsh et al., 2018), further going on to indicate the process of identifying strengths has the potential to be distressing. However, they concluded this is likely to be an important for the recovery journey.

> Engaging service users to look for strengths, etc. could be a very hard, possibly distressing and lengthy process due to long term self-worth/beliefs but is essential for long term recovery. (Survey, Chloe, female, lived experience)

9.3.2.1.3 Problems Live Outside of People. This sub theme reflects participants' interpretation and approval of the sentiment of asking not "what is wrong with you?" but "what has happened to you?" within the PNM. In other words, contextualising a person's experiences within their wider environment, including their past experiences as well as their political, social and environmental situatedness was received positively.

> In the care I received there was more focus on developing skills to stop 'problem behaviours' rather than seeing them as a survival tool that I felt I had no choice but to use. (Survey, Jane, female, lived experience)

The above quote encapsulates much of the critique of particular models for some service users, in understanding oneself to address mental health difficulties. A consequence of neglecting to address one's environmental and historical influences may be that service users are led to situate their difficulties within themselves. Jane found her experience of DBT frustrating for this reason:

> It felt like we were ignoring the point and we were putting all the blame on me. And I know that now, that it wasn't. If I didn't change, I would die [laughs] you know what I mean but at that time, I remember feeling like, 'everyone's telling me to change when the world has made me this way.' And it made it feel like I was the disordered

> person and therefore everybody else isn't responsible. And I didn't like that [laughs] at all, because I knew that the reason I was there was for the things that I had been through, which I mean, a person is shaped by their experience. And I was very aware of that, and yet it felt completely ignored. (Interview, Jane, female, lived experience)

9.3.2.1.4 People Cannot Be Put in Boxes. Participants reported valuing models and ways of understanding mental health that embrace its irreducible complexity, or at least that resist reductivism. This was particularly true in terms of participants appreciating the avoidance of labelling or attempting to understand individuals using other medicalised indices.

> The main strength is that it is based on the individual person as a whole, and from their own personal narrative instead of being based on a medical model which is based on numbers on a paper resulting from laboratory tests, exam results, etc. (Survey, Fatima, female, practitioner).

Although not generally the reported experience (Cooke et al., 2019), one practitioner participant indicated that this approach aligns with the orientation of many practitioners she had encountered, which may indicate support for the PNM:

> I've met a lot of people [who] want to not medicalise, um, the problems or difficulties or formulations. They are really interested in understanding the meaning behind the client's difficulties and using, you know, the psychosocial aspect, rather than medicalising it. (Interview, Delia, female, practitioner)

The use of narrative was felt to be a powerful support for mental health. Narrative-based approaches can "help to externalize the problem, separate from the person, within a social, cultural, and political context, creating the needed space for a person to experience agency," (White & Morris, 2019). Participants reported an emphasis on the role of narrative in keeping an individual healthy and grounded:

> I think this is necessary for strong mental health in any individual. We all need a continuation of narrative to remain healthy, have a strong sense of self and stable emotions and relationships in my opinion. Basing treatment around such ideas and models I think is very necessary and is a very good idea. (Olivia, female, both practitioner and lived experience)

Narrative was also thought to be helpful in motivating service users to change their behaviour using the insights gained.

> From experience, people generally benefit from making sense of their current problems with past problems. Not everyone is interested in knowing how the past shaped them; they sometimes just want to focus on what the problem is and how can they fix it. For the other group of people, knowing how the past shaped them and making links with present problems helps them to get to overcome their difficulties. (Survey, Jessica, female, practitioner)

9.3.2.2 The PNM's Legitimacy. Although attitudes towards the PNM were generally positive, when it came to a discussion of what would enhance its overall acceptability, participants provided a wider variety of perspectives related to the PNM. These related to features they appreciated, those which may not work as well, and strategies to bolster their views, all related to its legitimacy.

9.3.2.2.1 Boosting Trust in PNM. To create a stronger sense of trust in the Model, participants indicated the need for further (empirical) research to demonstrate the PNM's validity, alongside testing the Model with service users. It seems relevant to mention that 'further evidence' for participants seems to implicate notions of evidence-based practices (EBPs) that are informed by 'rational' or 'scientific' ways of knowing that effectively render other knowledge pathways second-class, including learning through experience or collaborative knowing (White et al., 2015).

One participant, however, indicated they felt that based on its description and factors alone, it would likely be helpful for particular service users. In terms of positivist notions of validity, this would translate as 'face validity,' although in other terms, perhaps 'practical wisdom' applies most closely.

> Yeah, I think that's also, um, I think within the Model itself, even without the stats as such, I think there's – there's definitely just on the naked eye, you can see how the information presented in this way would benefit clients … I can think about how well received it will be from them. (Interview, Delia, female, practitioner)

9.3.2.2.2 Compatibility With Current Ways of Working. Practitioner participants valued the compatibility of the PNM with their usual ways of working. This is understandable as although PNM was intended to be theory- and diagnosis-neutral, it has not been tested with a variety of modalities.

> The work I do is very much guided by the ACT [Action and Commitment Therapy], CFT [Compassion-Focused Therapy] models and I have a background training of person centred counselling. So, for me it fits well with trying to explore the individual's narrative in the most supportive way possible. (Survey, Lindsay, female, practitioner)

9.3.2.2.3 Valued Departures From Other Models. Although participants reported finding some similarities between the PNM and more familiar models, the PNM offers additional benefits because of its particular combination and approach. For example, in their survey response, Delia indicated, "I think it gives you more of an opportunity to think about the person's constructs which some other models don't really encourage as much." In her survey response, Yasmine (lived experience) added, "It also looks at how they are feeling about current treatment which is something that is not often talked about in therapy sessions."

However, one practitioner (Richard) raised the point that while welcomed by service users and even some practitioners, particular aspects of the PNM typically omitted by other psychological models may be an intentional choice to only address difficulties practitioners can assist with, presumably with the view that discussing topics outside practitioner remit would be damaging or unhelpful in some way. It is possible that this is a relic of the problem-solving 'can do, should do' attitude from the inception of the NHS (Plamping, 1998).

> In models in general is-is there a focus on psychology and, you know, emotions and identity and relationships, but the physical stuff tends to be kind of missed and I don't know whether that's because again, if we look from a problem-solving perspective, is that we often can't solve physical difficulties. (Interview, Richard, male, both practitioner and lived experience)

Richard anticipated psychological practitioners (as opposed to nurses or other more medically trained practitioners) resisting the inclusion of physical difficulties, ostensibly given the absence of interprofessional education that occurs in psychology training programmes (Pan et al., 2021) as well as across other caring professions. However, it should be noted that no other practitioners commented on this feature of the Model, negatively or positively, psychologically trained or otherwise.

9.3.2.2.4 Unhelpful Elements of the Model. Some features of the PNM were not received as favourably by other participants. Richard expressed aversion to the model's inclusion of 'quality of treatment,' citing a similar rationale as above regarding a desire to address only aspects of a service user's life that can be addressed by a practitioner and perhaps raising a question of ethics (Sheldon, 2011):

> Just because there's a lot of things that we can't change, like, you know, staff availability, um, you know, the regular care-planning reviews. A lot of this stuff kind of almost happens within the environment. And so for me, I would be quite nervous to kind of raise that. (Interview, Richard, male, both practitioner and lived experience).

Another respondent indicated they disliked the decentring of biological factors, indicating they felt they were absent in the PNM. A survey response from Hilda (female, lived experience) indicated, "The PNM doesn't really take into account other theories of mental health, e.g., biological. I believe there should be a combined approach to treating mental health."

9.3.2.3 Predicted Practical Utility of the PNM.

9.3.2.3.1 A Compass in Chaos - PNM as Organisational Tool. Participants indicated they appreciated the PNM's potential to facilitate more structure and organisation in a variety of ways. Participants, particularly staff, appreciated its potential role in guiding conversations or ensuring the formulation remains focused while covering relevant areas of a service user's life. Lizzie's survey response (female, practitioner) indicated, "My sense is that this model would encourage you to think broadly and cover all the ground before planning an intervention - therefore you are more likely to target the right things."

Another practical application of the PNM indicated by a participant with lived experience was as a template for structuring one's thoughts:

> If you've seen the progression and-and it literally kind of lets you break your thoughts down into those sections, so you can kind of structure your thoughts so going forward, it's – it's almost like a – a little life tool, you know. (Interview, Chloe, female, lived experience)

Similarly, another participant suggested the PNM may assist with organising service users' internal 'chaos.' Olivia's, (female, practitioner and lived experience) survey response

concluded: “I think that the PNM is great and should be used to help mitigate any chaos that a service user is experiencing.”

The use of psychological models conveyed visually was indicated to additionally be helpful in empowering service users, as expressed by Jessica, who believed that by providing boundaries and a resource both the practitioner and service user can refer to, it possibly acts to balance the knowledge (power) imbalance. According to Jessica (interview), “And not just for me to hold it together; if I had the formulation, I have it with the client; well, he’s got it. He’s got control. So it’s pretty much like a teamwork.”

9.3.2.3.2 PNM Creates Emotional Distance. The PNM was thought to facilitate a perception of distance between users and typically emotionally charged topics, such as one’s mental health difficulties.

One practitioner participant described the Model as a similar process to creative therapy and the perception of dissociation from emotional ‘closeness’ that particular approach creates.

> It’s, in a way, like in drama therapy, you – let’s say they say, ‘how do you feel? … they open a cupboard and they say, ‘pick something, uh, that describes how you feel’ and you pick something and you talk about it. […] It just packs all the rubbish around it, you know? It just cuts in straight to the feeling because you’re actually talking about a button but you’re talking about your feelings […] And the Model felt that way. That it – it made that space, you know? You could distance yourself (Interview, Jessica, female, practitioner).

This perception of distance was seemingly common, with other participants using words like “objective” (Survey, Mary, female, lived experience) and supporting service users to think “more logically” (Survey, Zoe, female, lived experience).

9.3.2.3.3 Record of Progress, Accomplishments to Help with Motivation. Like what was reported as being beneficial about care-planning from Poppy ward service user interviews was echoed by Chloe in terms of the possible value of referring back to previous records as evidence of progress in times of discouragement:

> When [a service user is] having an ‘I’m not doing anything; look, I’m failing, I’m this, I’m that’ … you’d almost have, like, a-a timeline of… we’ve shown you’ve got these strengths; you’ve said you’ve got these strengths.’ (Interview, Chloe, female, lived experience)

9.3.2.3.4 Thorough, Inclusive, Exhaustive. Another feature that participants reported appreciating about the PNM was its thoroughness in investigating the landscape of an individual's experiences. Richard in his survey response (male, practitioner and lived experience) illustrates: "I really liked the PNM. It brings a variety of factors to mind and really helps us drilled down into the detail."

One participant, however, felt there may be a downside to this thoroughness in that they felt there would likely be a substantial amount of overlap between categories, which may make it difficult to investigate coherently. Hilda, in her survey response (female, lived experience), "Most things that fit into one subcategory will likely also fall under the emotional one too. It may be difficult to pinpoint exactly what it was that triggered them to feel this way."

9.3.2.4 PNM as Inclusive but Unproven. In response to questions relating to inclusivity of the PNM for possible users, participants were optimistic but felt further consultation and investigation was necessary. Here, inclusivity was conceptualised as encompassing personal and professional identities, cultures, ethnicity, nationality, and any other facets that make individuals unique. This theme aligns with the ethical aspect of acceptability, a key tenet described within the theoretical framework of acceptability (Sekhon et al., 2017).

9.3.2.4.1 The PNM's Accessibility. The PNM was reported to be accessible by many participants. Statements like those below were common.

> I find that this is a clear, workable model that clients and professionals could follow and make sense of. (Survey, Richard, male, practitioner and lived experience).
> It's well written and easy to understand. It makes logical sense and service users would understand it. (Survey, Rachel, female, lived experience).

This was seen as advantageous for both staff and service users:

> Um, and being new to Psychology, I am not used to the jargon at all… So [pause] so when I saw the Model, the clear descriptions … I could understand straight away. I didn't have to research anything; you know, like, sometimes they say – even safety behaviours. If I speak to clients, they don't know what that means. (Survey, Jessica, female, practitioner).

However, not everyone held this opinion. There were particular concerns relating to the accessibility of the model for service users who are in distress or possibly overwhelmed with details.

> I think that would, you know, put me off [laughs] slightly to begin with, because you know, there's a circle and I'm like, 'what goes where?' but easily overwhelmed by stuff when I'm in distress or, like, suffering or whatever, do you know what I mean? (Interview, Jane, female, lived experience)

Richard concurred with this concern; however, he raised an interesting point around whether it is possible for formulation to be anything but somewhat complex.

> I mean, it really looks really straightforward to me. But I think a lot of the boxes and stuff made make people a bit overwhelmed, I guess. Um, but I guess that's just the nature of formulation; there's always gonna be an element of that. (Interview, Richard, male, both practitioner and lived experience).

9.3.2.4.2 The PNM Supports Client-Centred Collaboration. Those participants who commented on collaboration all agreed the PNM supports a partnership between service users and practitioners and promotes a client-centred orientation. In her survey response, Alice, (female, lived experience) indicated "The collaboration between a therapist and a service user is one other strength of this model. It allows the service user to take part on his own recovery rather than relying fully on the therapist."

9.3.2.4.5 Meaning and Identity Possibly Support Cultural Differences. Some participants felt the PNM somewhat accounts for cultural diversity via its inclusion of meaning and identity. For example, one participant indicated that in incorporating meaning, the PNM goes some way to accommodate various cultures or individual differences.

> I think the fact that it talks about the meaning and talks about, um, the person's experiences in itself. It validates even really wanting to know about that, validates the person as an individual, including potential cultural influences. I think some other models really don't take that into account. (Interview, Delia, female, practitioner)

A curious stance was advocated in approaching the topic of difference and its impact on the service user.

> I think that, first of all, what we need to do is make sense of it. If we were looking at identity, I mean, in some ways, that – that feeds straight into that question. If someone comes from a – from a, you know, a minority background, I don't make an assumption, you know, um, you just try to be curious about it […] The identity probably would tick that anyway. (Interview, Richard, male, both practitioner and lived experience)

9.3.2.4.6 Improving Inclusivity. Participants provided suggestions regarding ways to improve the inclusivity of the Model. The first was to incorporate cultural identity in a similar way to how positives are included in the PNM: as conceptualising it as incorporated within every factor.

> I think, in some ways, having a [pause] it may be worth, if you're looking at strengths and resources on one side – on the right side is having [pause] um [pause] that – that explicit. You know, culture, and, um, cultural identity. Or something. (Interview, Richard, male, both practitioner and lived experience)

Other feedback parallels much of the literature and campaigning relating to 'nothing about me without me.' To ensure the Model is relevant to as service users likely to undergo psychological formulation, relevant members of groups would need to be consulted.

> I think making sure that you ask a diverse group – cultural group for feedback is something that could help to be more culturally appropriate. I think at this stage, I don't know what additional information to put in, um, or ask of – within the formulation itself, but I think because anything I think that I suggest would be an assumption on my part. (Interview, Delia, female, practitioner)

9.4 Contrasting Qualitative and Quantitative Findings

Qualitative results paralleled the quantitative results. In general, participants reported positive views towards the Model. Participants appreciated that the PNM supports collaboration between practitioners and service users. Both staff and service users reported that further research and exposure to the Model would bolster its perceived legitimacy.

Responses to the 'negative aspects' quantitative subscale were more weighted towards the middle Likert options, with one to three participants responding on the negative side of the scale. This mirrored some of the concerns relating to narrative reported in interviews and there was alignment in responses between those with lived experience and practitioners to the question relating to the likelihood of downsides, with almost all participants regardless of their 'identity' choosing one of the top three Likert options, 'no,' 'a couple,' and 'a few,' downsides likely. There was general alignment between participant

'groups' to the question, "How much discomfort do you think is likely to be experienced during the development of the PNM?" with the highest number of participants per group selecting 'slight discomfort' (41.7% for practitioners and 42.9% for participants with lived experience).

9.5 Implementation Mixed-Methods Analysis

9.5.1 Implementation: Quantitative Data

Only service users were asked to respond to quantitative questions relating to implementation.

In response to the first question, "Thinking about the last time you received services, were you encouraged to tell your story?" 11 (78.6%) of participants responded 'yes.' To the question, "Have you worked together with staff to understand your difficulties before?" 13 (92.9%) responded, 'yes.' To the question, "Have you worked together with staff to understand your strengths before?" 10 (71.4%) responded 'yes' and four (28.6%) responded 'yes' to the question, "Has personal meaning been discussed with you in care-planning?" with the remaining 11 (71.4%) responding 'no.' In response to the final question, "How involved have you been in your care-planning?" the highest proportion (six; 42.9%) responded 'somewhat' while one (7.1%) responded 'not at all,' three (21.4%) responded each with 'reasonably' and 'mostly' and the remaining one participant responded, 'very.'

9.5.2 Implementation: Qualitative Data.

Five themes were developed relating to the PNM's possible implementation. These included (a) Embedding through training; (b) Resistance as default; (c) What hinders and helps collaboration; (d) Narrative and talking about past events distressing; and (e) Possible applications and adaptations of the PNM (see Table 9.3). These themes will be explored in turn below.

Table 9.3

Summary of Online Implementation Themes

Theme	Subtheme
Embedding Through Training	Ongoing Support Required Practice as Important for the Understanding of and Using the PNM Showing PNM in 'Real Life' Training Integral to Effective Implementation
Resistance as Default	The Impact of Setting Overcoming Resistance Implementing Change Can Be dangerous Passion and Caring Will Orient Towards Change
What Hinders and Helps Collaboration	Time Needed for Meaningful Collaboration Concrete Ways to Provide Support Barriers to Service User Collaboration Narrative and Talking About Past Experiences Distressing Risk Relating to Timing and Destabilisation of Service User Support for Distress Caused by PNM
Narrative and Talking About Past Events Distressing	Risk Relating to Timing and Destabilisation of Service User Support for Distress Caused by PNM
Possible Applications and Adaptations of the PNM	Tailoring Approach to 'Disorder' Using PNM on One's Own

9.5.2.1 Embedding Through Training.

9.5.2.1.1 Ongoing Support Required. Aligning with Poppy ward staff in the focus group in Chapter 8, participants in this study spoke of requiring ongoing support for both staff and service users, although for staff this was mostly related to adherence to the Model as well as peer support.

> One of the things that does happen or can happen is certainly that something's being introduced within the service and then it's introduced one time and one time only and then people are almost kind of expected to run with it and there's no follow-up. I think it would be quite helpful for people to have a go-to almost consultant person to check in to make sure we're formulating in the way that's intended. (Interview, Delia, female, practitioner)

This type of ongoing support has referred to elsewhere as 'boots on the ground' (Collins, 2018). Delia further suggested "a group session every two months or every four months or so, just to kind of check in." This type of support was reported as helpful by Richard, who described the DBT consult as being helpful both because "it brings so many different perspectives" but also "There's a set criteria or rules about how we conduct the consult and you don't divert from it. There's such a strong emphasis on adherence."

Interestingly, the rigidity described as helpful by Richard was difficult to tolerate for Jane. It may be that structure and inflexibility is valued in some regards or contexts but is experienced as more limiting in others. For staff, embedding new practices appears to require structure and consistency.

9.5.2.1.2 Practice as Important for the Understanding of and Using the PNM. Many participants reported a requirement for practice using the Model to better understand it as well as improve their confidence. Like what was reported by Poppy, Bridget (female, lived experience) in her survey response, "To fully understand a method I think it is important to have some experience with it." This was echoed in a survey response by Jane (female, lived experience) "I think practice using the model would be helpful. I understand better by doing."

9.5.2.1.2 Showing PNM in 'Real Life.' Another prominent sub theme was the advice for future training to involve demonstrating the 'real life' application of the PNM. For participants, this looked like real-life examples, either "a training session with an example user" (Survey; Ursula, female, lived experience), or, as the quotes below indicate, bringing real-life service user cases to explore using the PNM.

> Life examples of clients …I think [is] what really helps is to see what – how it's helped someone… and then people see, 'oh, it's improved this, this, and that area in that person's life.' … Not theoretically, but I think that, you know, a practical example. (Interview, Jessica, female, practitioner)

9.5.2.1.3 Training Integral to Effective Implementation. A large proportion of participants reported that training would assist with the implementation of the PNM. Most participants had responded 'training' to questions relating to how best to support understanding and confidence in the use of the PNM. This aligns with much of the literature relating to implementation of new interventions.

In this research, one participant contextualised their response with reference to ensuring service users' needs would be met. In Mary's survey response (female, lived experience) "Further training could be required to ensure that professionals have met all service users' needs as well as ensuring that they feel a sense of safety and belonging."

In her survey response, Isla (practitioner) indicated that training should be accompanied by thoughtful application of the Model, "Individuals using this should be thoroughly trained and think carefully how they should be using it."

Consistency was additionally a rationale for staff training. As stated by Chloe (interview), "[training] makes sure everyone's doing it in the same – everyone's on the same hymn sheet."

Training was also seen as helpful in upskilling MDT staff in psychological knowledge. For example, in her survey response, Jessica (female, practitioner) indicated,

"For nurses and other professionals on the wards it's too much to include [talking to service users] in their practice on daily basis; they usually feel that patients would benefit from psychological formulation provided by someone psychologically trained." Jessica expanded on this in her interview response "If I remained working as a nurse, I would definitely love to learn from psychologist how to conduct formulation; it would improve my knowledge about the service user and their experience."

9.5.2.2 Resistance as a Default. Participants spoke about resistance as an expected and standard position taken by staff, although this resistance was described as emerging from a variety of sources, including personality, culture, and a lack of consequences for non-adherence. Although resistance was described as an automatic position taken in the face of change, this was not viewed as insurmountable, although persistence in the face of obstinance was not advised.

9.5.2.2.1 The Impact of Setting. Overall, participants expressed that an acute ward setting is among the most challenging contexts in which to introduce a new intervention. As stated by Richard, it is particularly challenging to implement change in a context where service users have "been detained. I mean, I thought you were very brave doing it on an inpatient, to be honest? Because it's – just by the nature of, and the inpatients now a lot less informal admissions, anyway."

One participant indicated it would be particularly challenging to introduce an intervention such as the PNM in inpatient wards, which were thought to be 'medicalised,' a model embedded within the operation of inpatient wards which resists change towards a recovery orientation (Lorien et al., 2020).

> In a community team, I think it's, uh, much easier than on an inpatient ward. Whereas a lot of the staff I've come across it's more, 'well, they just need – we just need to check with the meds and they'll be fine.' (Interview, Lindsay, female, practitioner)

Participants cited a variety of explanations for the sources of resistance. These simply included that "people hate change," (Jessica) 'personality' (Jessica); and that staff's plates are already full:

> It can be very tricky to implement anything new on an inpatient setting as it is still (unfortunately) medicalised. Staff are busy putting out fires, they don't have time to look for the source (Survey, Lindsay, female, practitioner).

There was also a perception of some staff having little concern relating to the professional consequences of not taking on new ways of working. This particular theory relating to orientation towards change is not one commonly reported in the literature and was only reported by one participant in this research but offers an intriguing explanation for change resistance:

> I came across lots of nurses who just do it as they can't get a job elsewhere and as there is a constant demand on employing mental health staff they know that they will always have the job so they don't want to change their attitude, no matter what is given to them (Survey, Jessica, female, practitioner).

Others theorised that staff get 'stuck' in their roles as, according to Richard, "A lot of them have been there year […] But also, just the nature of the ward, you know, people don't want to be there." Jessica concurred: "There's a lot of different attitudes towards, um, uh, change. And [people] get stuck in their ways."

There was additionally a feeling that formulation 'belongs to Psychology' or professional silo-ing. The following quote illustrates some of the feelings thought to prevent MDT staff members from taking on more traditionally psychologist roles, specifically feeling that, for example, formulation is not within their wheelhouse. In her survey response, Jessica (female, practitioner), "So I can imagine for nurses it would be just "another thing to do" that they generally feel psychologists should do."

9.5.2.2.2 Overcoming Resistance. Participants offered strategies or factors related to overcoming resistance. This included 'selling' the benefits of the intervention. Richard, a former ward manager, stated "If I could see okay, this is going to direct me into a course of action and this action's going to be X, Y, and Z that's—that's more likely where you'll get buy-in from people." Richard went on to indicate the benefits should ideally be for both staff and service users, such as "if this can help us get people treated quicker and discharged," which was echoed by Jessica.

Support from management was also felt to motivate staff to implement the Model, partially because "people will do [pause] if they're told" (Jessica) but also without the

support of management, staff with less power are unable to effectively make any changes on their own.

> In my case, as an Assistant Psychologist, I-I think one of the biggest factors is having the backing of the qualified members of staff. If they – if they're not aware, or if they don't like it, or they think it's, um, just another formulation, you can't just go fly with something. (Interview, Lindsay, female, practitioner)

9.5.2.2.3 Implementing Change Can Be Dangerous. Two participants (Chloe and Jessica) drew a darker picture of the danger of seeking change. Using the example of student nurses on practicum or freshly joining the workforce having been exposed to newer, more socially just ideas, one participant, a mental health practitioner, indicated that:

> If you want to make changes sometimes and-and people disagree generally, they can-you can lose job. You know, you would get bullied. But […] you need to be very careful with how you present it, so you don't sound like you're patronising and all this. […] If you try to bring on change and people don't like it because it will give them more work to do, um, you will, you know people will get bullied and people lose jobs… if you want to keep your job sometimes you need to be qui-you need to shut up, basically. (Interview, Jessica, female, practitioner)

This extract implicates politics and power as playing a major part in impeding change. Students are described as having to navigate more established staff's egos in suggesting change and facing bullying or worse should their approach be poorly perceived.

Another participant, Chloe, an individual with lived experience undertaking an educational course alongside mental health practitioners, indicated a similar risk: "I've, you know, heard things on the – on the [course's social media] group, you know, it can be daunting, intimidated; you could lose your job if you take these kind of things upon yourself."

9.5.2.2.4 Passion and Caring Will Orient Towards Change. While the default stance appears to be resistance to change, some participants indicated that staff who care about service users and are motivated to improving their practice can be convinced to try new practices. Interestingly, this was described not so much as a cultural influence, but the impact of passionate individuals in inspiring others. Chloe exemplifies this perspective, "It is the top-down support and it just takes one person in the team and it has to be from the top down to instil that passion and that drive that, then, filters down."

9.5.2.3 What Hinders and Helps Collaboration. Participants spoke about factors that promote the engagement of service users in their care as well as those that impede this involvement.

9.5.2.3.1 Time Needed for Meaningful Collaboration. A major contributor to enabling a partnership between staff and service users was thought to be time. Service user participants reported requiring time to be acquainted with new practices as well as persistence and patience while they potentially react emotionally. One service user participant described previous experiences in services being denied the opportunity for true collaboration given staff reactions to their anxiety.

> My care could have been improved with more time taken to understand my thoughts and feelings. When anxious I tend to 'word vomit' and it's quite apparent to everyone I'm talking too. People then sort of rescue me and say what they think I want, or just take over and do it for me- and because of the anxiety I just agree (Survey, Jane, female, lived experience).

While time was highly valued in supporting collaboration, it is one of the most limited resources within services. Concern was expressed relating to whether the PNM would be practical given time limits. According to Delia (interview, female, practitioner), "I think the factors would be whether they would-we would have enough time depending on the client's own narratives and how much they explore in each-each, uh, section."

Time was reported to facilitate the development of trust, which was reported to enable more meaningful engagement.

> I think that I would need to know someone enough, which is a bit subjective… I need to feel a certain level of comfortable, and I know that wouldn't mean, like, we're best friends at the shop or whatever, but someone that I could trust, you know, to an extent to be able to go through it. (Interview, Jane, female, lived experience)

Limited time can lead to limited perceived collaboration, including limited opportunities for explanation, as well as frustration. According to Jane's survey response (female, lived experience), "It always felt like a rush to be in and out. I had a care plan and was involved in its development, but it felt like the professionals just wrote it for me to be honest." In her survey response, Ursula (female, lived experience) echoed this: "It was all decided for me. I had limited time or knowledge of being able to voice a preference."

9.5.2.3.2 Concrete Ways to Provide Support. Participants offered concrete ways to provide support for meaningful collaboration. This included being asked "what did I want to do next/what do I think would be helpful for me?" (Hilda, Survey), and support to "[Reach] conclusions on my own…to feel more involved and that would increase my overall engagement" (Survey, Alice, female, lived experience).

Some participants with lived experience emphasised relational support. According to Delia in her interview, "The things that really worked were, um, not the talking but the listening and the actually being heard, body language, you know."

9.5.2.3.3 Barriers to Service User Collaboration. Both staff and lived-experience participants also discussed the barriers that may impede meaningful service user collaboration in the PNM, which parallel wider barriers to collaborative treatment in other settings and using other models.

This included service user capacity for reflection, referred to as 'insight' in more clinically oriented literature:

> I've been thinking about the meaning about yourself that you've taken, that is a heavy question. I was just wondering in terms of the-the client group is – would they necessarily have that insight? (Interview, Richard, male, both practitioner and lived experience)

'Active passivity', which is a DBT term "described as a tendency to approach problems passively and helplessly instead of actively and with determination" (Falklöf & Haglund, 2010) was reported by a subset of staff and service users to likely impede motivation to participate in treatment. Richard (interview, male, both practitioner and lived experience): "Sometimes you come across clients that basically say, you know, I don't I don't wanna get involved in this; you know, just-just cure me. Just problem solve my stuff for me."

> If I was feeling wilful, then I wouldn't use it, if you know what I mean? Like, if I was feeling like I want somebody else to fix this for me; I don't want to talk about my problems; I want a quick solution, something I've done in the past, I wouldn't even look at it. (Interview, Jane, female, lived experience)

Trust was also thought to impede willingness to engage in collaboration, which was thought to be a barrier more likely to occur with service users with a lengthier history of relational difficulties:

> There's always going to be some people that aren't interested and so they're not going to play ball. But I think with those people, I think – I don't want to make assumptions or generalise, but it's distrust, it's, um, they've never wanted to, had the opportunity of actually being listened to when they open up, or they're scared; they've buried it so deep. (Interview, Chloe, female, lived experience)

Interestingly, one participant reported that to expect service users to actively engage in their treatment may be experienced as onerous or burdensome:

> There doesn't seem to be a way of [addressing] this without burdening the service user with having to also learn different methods and manners of treatment when they evidently are burdened enough (Survey, Olivia, female, practitioner and lived experience).

Another participant indicated that practices deemed to be collaborative on the surface (Grundy et al., 2016) may not be sufficiently so.

> I was told what my care plan was and asked if that was okay without being given more options. This can be difficult for some people, as saying it's not alright could be anxiety-inducing to them. Being able to talk through it more in a more in-depth way with more options would have been beneficial (Survey, Yasmine, female, lived experience).

9.5.2.4 Narrative and Talking About Past Events Distressing. Risk as it relates to the application of the PNM was often discussed by participants. Generally, the risk was seen to emerge from discussion of past experiences given the prevalence of prior trauma and abuse in mental health service users (Sweeney et al., 2016). Participants spoke of both the likelihood and nature of the risk posed as well as methods to manage this risk.

9.5.2.4.1 Risk Relating to Timing and Destabilisation of Service User. A practitioner participant indicated they would gauge the likelihood of a negative impact of discussion of past experiences in deciding how in depth or even whether to broach the topic of past experiences with a service user. According to Delia, "It depends on what their presenting difficulties are. If they're presenting with high risk … I wouldn't encourage them to talk so much about their past experiences for the fear of further destabilising them."

Service users as well as staff indicated this should be a consideration, with one participant with lived experience indicating that on reflection, in her past, she may not have been in a position to engage in the PNM without experience a high degree of emotional upset.

> I would probably check beforehand, like, element of risk, I suppose. Like, obviously that depends on the timing of the person and where they are. You know, at certain points in my, you know, mental health world, there's no way I could've talked about my history without it causing some significant distress. (Interview, Jane, female, lived experience)

The acknowledgement of the possibility of distress or even re-traumatisation resulting from exploring past experiences was said to be a strength of the PNM: "Re-traumatisation risks were taken into consideration resulting in a great strength, as it is a real possibility" (Survey, Julian, male, lived experience).

9.5.2.34.2 Support For Distress Caused by PNM. A few participants offered suggestions for support regarding the potential distress caused by reviewing past experiences. Suggestions included a warning of potential distress or offering telephone support lines such as the Samaritans. Jane suggested slightly more personalised options, including the option to access a PNM-trained practitioner via:

> A direct line sort of thing within set boundaries, you know, nine to five, Monday to Friday if you wanna discuss. Or maybe like a more – not like a questionnaire, but you know what I mean, like when you have a very brief sort of set sort of questions to make sure the person's, like, okay to leave sort of thing. (Interview, Jane, female, lived experience)

9.5.2.5 Possible Applications and Adaptations of the PNM. Participants offered a variety of applications for the PNM. This included specific applications or contexts, including "family-type therapy" (Chloe), "perinatal [teams]" (Chloe), and "reflective practice or supervising" (Jessica). Another participant suggested that "CPNs [community psychiatric nurses] would love this" (Survey, Lindsay, female, practitioner).

Ursula, a participant with lived experience, suggested including a PNM template with the questionnaires sent to service users in advance of assessments via the NHS. Another participant suggested a much broader implementation:

> I feel that this model needs to be used widely across psychiatry, psychology and nursing. There is a massive gap in formulation within care coordination and I feel this lengthens the episodes under services by a large margin (Survey, Richard, male, both practitioner and lived experience).

9.5.2.5.1 Tailoring Approach to 'Disorder.' There were some conflicting perspectives relating to whether it is advantageous or desirable to adjust the PNM according to the 'disorder' or difficulties experienced by service users.

One practitioner participant indicated the PNM would likely require alteration to be suitable for application to service users with a diagnosis of personality disorder.

> As a general model is has a lot of strengths; however, there would likely need to be additions for PD [personality disorder] clients (for example, some of the dialectical dilemmas which are in the BPD formulation) (Survey, Richard, male, both practitioner and lived experience).

Another practitioner participant indicated that her judgement relating to adjusting a therapeutic approach according to the service user's particular challenges is relatively flexible.

> I think it depends which – I mean, I don't like saying 'disorder,' [but] I think it just depends on what disorder it is. So, uh, if I exclude psychosis… yeah, I share the formulation but I think it's so individual as well. (Interview, Jessica, female, practitioner)

Some participants with lived experience indicated they did not appreciate practitioners using diagnosis to guide their approach to care as they found it limiting. Given that diagnoses such as BPD are described as 'heterogeneous' and are believed by some to

present via various subtypes (Hallquist & Pilkonis, 2012), this does beg questions relating to how best to approach and make sense of complexity. According to Zoe's survey response (female, lived experience), "[I prefer a] more personal analysis of what I am facing rather than a general overview of what experiences most people would be facing that are diagnosed with the same disorder."

9.5.2.5.2 Using PNM on One's Own. A subset of service user participants reported they could see themselves using the PNM on their own:

> Uh, I imagine it – when I first doing it – I could imagine this applying quite well for myself. That's why it, of course with a professional, that's I think the standard way of using it, but why I liked it is because I realised that I could be using it by myself. (Interview, Karen, female, lived experience)

However, one participant cautioned that this may result in a limited narrative.

> The patient has power in the choice of where and what to focus on and although it is a strength for the model and results in an empowerment for the service user it may also lead to an oversighting of causal problems that the individual does not consider major, although they might be. This, though, may be simply fixed by an expert clinician and their developed ability to spot causal traumas. Therefore, it may not be easily applicable by anybody (Survey, Julian, male, lived experience).

9.6 Contrasting Qualitative and Quantitative Data

Participants further explored the topic of the risk possibly introduced by the PNM, although this was considered in terms of implementation. The risk posed by the exploration of past experiences was seen as an important consideration for both service users and staff; however, service users valued the opportunity to explore past experiences and have this understanding play a part in the wider formulation. In the quantitative survey, 78.6% of participants with lived experience indicated the last time they had received services, they were encouraged to tell their story. However, in interviews with participants with lived experience, it was indicated that an understanding of these experiences did not inform subsequent treatment and thus at least in some cases a more holistic approach may be appreciated.

Related to a gap in whole-person care provision is the finding that 71.4% of service users had not discussed personal meaning with staff in previous experiences of care and 50% felt only 'somewhat' or 'not at all' involved in their care-planning. Thus, the PNM with its

focus on meaning and supporting collaboration, has the potential to support the implementation of these practices.

9.7 Discussion

This research was intended to address aim 4) to explore the acceptability of the PNM for wider stakeholders and solicit suggestions for its implementation, including any suggested improvements. The following research question was addressed:

5. What are wider stakeholder (clinicians and/or individuals with lived experience of mental health difficulties) views of the PNM and its acceptability?

9.7.1 Acceptability

A subset of acceptability themes align with key domains of the acceptability theoretical framework (TFA; Sekhon et al., 2017). For example, the TFA's affective attitude, perceived effectiveness and ethicality, map on to 'PNM is 'very good,' 'Predicted practical utility of the PNM' and 'PNM as somewhat inclusive' respectively.

Overall, the PNM was received positively, particularly with respect to its strength focus, although some participants did express some concerns about applying the PNM uncritically. Some participants felt the mere suggestion of strengths for some service users can be experienced as invalidating and others may struggle to identify strengths or find this process distressing. Robertson and colleagues' (2018) findings support this, and further support the difficulty of identifying positive aspects about oneself. For her thesis, Robertson developed a recovery narrative and an autoethnography; in a reflection of her experience, she stated "I had to search for the right words. Reframing was difficult! However, the reflection and reframing that I did as a result of developing these positive vignettes allowed me to consider the lessons that I have learnt over my recovery journey… Reframing had supported my renewed agency" (Robertson et al., 2018, para. 20). For Robertson at least, searching for and reframing experiences as positive, while difficult, was rewarding.

Relating to aspects of the PNM and how they may be perceived or approached by practitioners, a degree of professional silo-ing was suggested to exist, specifically amongst nurses and psychologists. While interdisciplinary educational gaps have been reported in the literature, the barriers identified tend to relate to differences in curricula and finance rather than staff attitudes (Newhouse, 2010). One practitioner with experience as both a therapist and a nurse indicated that Psychology staff would be hesitant to incorporate physical factors within a psychological formulation while other practitioner participants suggested that nurses

may resist applying psychological formulation given their views of whose role remit this should fall within.

Echoing the Poppy ward service user interviews (Chapter 6) relating to the practical value of care plans, participants with lived experience in this research indicated the PNM may offer a timeline or helpful record to look back on to reinforce progress and offer hope.

An especially important discussion related to the PNM's inclusivity relates to the feedback surrounding the need for additional input from various cultural groups and from individuals marginalised identities that are not often addressed in mainstream therapeutic models. Conyer (2020) calls for individuals such as herself (and me), who possess unearned privileges, to defer to groups or individuals with 'cultural authority' to avoid what Conyer (2020) calls 'cultural competence' which is considered a form of racism on its own by "conflating culture with 'non-white' racial identity" (p. 104).

Findings relating to ensuring the cultural relevance of the PNM led to few concrete directions except to ensure a more diverse range of identities and perspectives was sought. Given almost all participants in this thesis were white or white-presenting, this is an entirely valid suggestion. As suggested by Faulkner (2020), mental health researchers need to be careful to avoid whiteness as the reference population to be ethical, effective, and support decolonisation within the mental health arena.

9.7.2 Implementation

Mirroring the results found in the focus group with Poppy ward staff, participants recommended the PNM is best embedded through ongoing support, training and overall investment in time and resources to adequately familiarise staff and ensure their comfort and confidence with the Model.

Resistance was described by participants as a natural and inevitable reaction to proposed change and some staff may not be motivated to take it on. In addition to 'stuckness' and being overburdened, novel theories behind this resistance were offered, including some staff possibly feeling unmotivated to change due to a lack of professional ramifications. Shield and Ward (2001) lends support to this phenomenon reported by a practitioner staff member relating to nurse resistance to new practices: shortages of nurses means they can remain in role and that this security means they do not feel the need to take on 'extra work,' although Shield and Ward (2001) found that a lack of training opportunities partially led to the dissatisfaction of nurses in the first instance.

Paralleling the Poppy ward staff focus group findings, the importance of 'selling' the benefits of the PNM to staff was discussed. In this phase, participants spoke of 'selling' the PNM to address resistance, particularly in an inpatient setting. However, the general consensus was that some staff are more open to change and can be convinced through adequate motivations; for example, participants suggested providing practical examples, possibly incentives, and actively demystifying 'formulation' may influence staff. As staff in the Poppy ward focus group proposed, individuals may be most swayed by a new practice by doing it and experiencing its benefits.

A serious concern expressed by some participants was that in pushing for change in some organisations, this can be perceived as threatening and can lead to change-seekers being ostracised or even be at risk of losing their job. The themes and subthemes related to staff resistance and time being in limited supply reflect wider discussions relating to the strain on the NHS. For example, the findings related to staff fearing to suggest change for fear of losing their jobs or bullying relate to a 'climate of fear' reported by Wilkinson (2015) who reports there being 'shocking accounts' of staff having raised concerns to management only for them to be ignored or mistreated. Thus, effective change may entail speaking directly to trusted other staff members and appealing to their desire to provide the best possible care for service users may be more effective than pushing for unpopular change.

This research found that to facilitate meaningful collaboration, time is needed to effectively explain processes to service users and build trust. According to Sheldon (2011), a Mental Health Act Commissioner with lived experience, "You cannot impose involvement and, to be meaningful, involvement has to start with the service user. Sometimes this can take time. It requires the service user to be in control as much as possible. It requires listening, gaining an understanding of the individual, taking an interest, not judging or imposing values" (p. 21). The difficulty identified, again paralleling the Poppy ward focus group, is that time is one of the least available resources in services.

An important finding that relates to staff focus group findings (Chapter 8) involves the perceived risks associated with narrative or addressing past experiences. While overall discussion of past experiences being offered as an option for users of the PNM were positively received by participants in the present study, both staff and service users did add the caveat that risk should be a consideration in broaching the topic. There has been criticism of the resistance to engage with risk in the literature (Marsh & Kelly, 2018). However, participants in this research did not outright advise against this practice, instead to gauge the timing of the service user in their recovery journey, whether their existing skills could

sufficiently support them should they become distressed, as well as the presence of support systems such as help lines or check-ins.

The topic of timing as it relates to a service user or individual with lived experience's recovery journey echoes the questions asked in Robertson and colleagues' (2020) work on the development of personal narrative workshops to assist with recovery, which included: "Is there a particular stage of recovery that developing a personal narrative is more suited for?" (p. 488) and "Should developing a personal narrative be a one-off exercise or part of an ongoing part of an individual's recovery process?" (p. 488). It bears mentioning there is no known affiliation between Robertson and colleagues' 'personal narrative' and the PNM explored in this thesis.

Participants offered suggestions for use of the PNM outside of the specialist inpatient ward setting it was developed for and within which it was originally tested. For example, as providing the scaffolding for supervision; assisting to resolve disputes between staff; and in family therapy. This suggests the PNM's possible utility in a variety of settings, possibly without significant alteration.

Despite the goal during the development of the PNM was for it to be applicable across psychiatric diagnoses, one staff member (Richard) both in the qualitative survey and the interview raised the concern the PNM would likely need to be modified to be applied to individuals with a diagnosis of BPD. This was the only population that was identified specifically as requiring modification, which may be a product of the work setting of participants involved in this research, which was primarily community mental health, although interviewees spoke of a more varied employment history. Specifically, Richard noted the need to include "dialectical dilemmas" in a formulation of service users with a diagnosis of BPD in the qualitative survey and spoke about the potential for a focus on positives and strengths to invalidate service users with a diagnosis of BPD, who may find the suggestion that they have strengths at odds with their own perspective and thus become distressed. A subset of service users indicated that tailoring an approach according to diagnosis would be experienced as restrictive. A more idiosyncratic approach is exactly what formulation aims to support (Macneil et al, 2012).

Interestingly, relationships between staff and service users were rarely mentioned at any point in this data, even in the context of the therapeutic relationship. Trust in the context of supporting collaborative application of psychological interventions was not prevalent, and service users were primarily those who discussed this. This can be compared to Rushton and colleagues' (2020) study on the acceptability of a telephone-delivered psychological

intervention which found the development of therapeutic relationships is an important aspect for service users. This may have been the consequence of this phase of the research being largely theoretical in nature and thus pragmatics were closer to mind.

10. Chapter 10 Discussion

10.1 Chapter Overview

This chapter presents an overview of the main findings of this research, synthesised from Streams 1 and 2. These findings are contrasted with existing literature and theories. The research aims and questions are then restated, followed by the central contributions offered within this research, including the contribution to knowledge, practical and methodological implications, as well as implications for practice and mental health services. Limitations of this research and suggestions for future research follow. The chapter concludes with a personal reflection.

10.2 Key Findings and Comparison to Literature

The main findings from each empirical chapter and where they intersect are presented in Table 10.1. The following section contextualises these findings within the wider literature, offering theories of explanation.

Table 10.1

Summary of Intersecting Findings

Findings	Stream 1		Stream 2	
	Chapter 5	Chapter 6	Chapter 8	Chapter 9
	Poppy Staff Interviews	Poppy SU Interviews	Poppy Focus Group	Wider (online) Acceptability
Importance of relationships: SUs with diagnosis of BPD	X	X		
Importance of informal relationships	X	X		
Importance of commitment to empowerment	X	X	X	X
Importance of and barriers to collaborative care	X	X	X	X
Time as an enabler of relationships and engagement	X	X		X
Importance of staff specialist knowledge and education	X	X	X	X
Alternatives like PNM could add meaning / coherence	X		X	X
'Selling' PNM necessary			X	X
PNM's strengths focus adds value			X	X
Risk presented by narrative and how to manage			X	X

10.2.1 Importance of Relationships

Stream 1 participants, including both staff and service users, emphasised the importance of good relationships across the ward for a positive experience of care. Much has been written regarding the importance of the relationship between service users and staff and its foundation for interaction and support (Newman et al., 2015) as well as service user satisfaction (Sweeney et al., 2015). The following discussion centres on the findings within this research that reveals different facets than those typically described in existing research.

10.2.1.1 Good Relationships Between Staff and Service Users With a Diagnosis of BPD. In the context of the literature relating to relationships between service users with a diagnosis of BPD and staff, it is important to highlight Poppy ward staff rarely spoke of difficulties establishing relationships with service users (while acknowledging particular relationships may be stronger than others). The state of this relational landscape differs markedly from Bland and colleagues' (2007) work, indicating that service users with a diagnosis of BPD "experience chronic feelings of emptiness that can cause dependency issues with the nurses, while simultaneously resisting developing a rapport with them because of the patients' mood instability and previous negative experiences with relationships" (p. 207).

Paralleling staff reports of relationships with service users, service user participants reported generally good relationships with all staff members, although again indicating their relationships are particularly close with specific staff members. This contradicts some of what has been written about relationships between service users with a diagnosis of personality disorder, whose 'intense' emotions, according to Bland and colleagues (2007), vacillate between praise and ridicule of nurses; this instability leads to intense anger that may result in physical altercations. Bland and colleagues (2007) further describe the tendency for service users with a diagnosis of BPD to 'split' staff or appraise them as existing as absolutes: bad or good, where one group of staff are 'idealised' and the other 'bad,' and are 'ridiculed and berated.' Again, there was no evidence of this occurring in Poppy ward.

10.2.1.2 Importance of Informal Relationships. The relationship between staff and service users was thought to be supported by informal or non-clinical time spent together away from the ward (see Chapters 5 and 6). This aligns with Hopkins and colleagues' (2009) findings, who found service users value informal opportunities to connect with staff. The informal nature of this time spent together combined with the promotion of activities to counteract the boredom on acute wards widely reported in the literature addresses many of the concerns expressed from the service user perspective, as reported recently by Foye and colleagues (2020). Activities combined with staff involvement in these activities addresses the two main areas of importance implicated in inpatient service users' experiences of treatment according to Walsh and Boyle (2009). Poppy ward staff's equal emphasis on informal relationships varies slightly from the literature, with Delaney and Johnson (2014) finding that staff tend to place a higher emphasis on engagement with service users, which is a slightly different construct and implies a more professional connotation. The description of activities and relationships by staff and service users are akin to that of friendship, which was reported by Molin and colleagues (2016) as well as Lilja and Hellzen (2008), who found service users crave every day, friendly activities (similar to findings by Jones et al., 2021) but this often being denied. Molin and colleagues' findings (2016) indicate these kinds of ordinary interactions are frequently disparaged in service contexts.

10.2.2 Importance of Commitment to Empowerment

Participants from all empirical phases of data collection identified meaningful collaboration as important for positive experiences of care, emphasising the importance of engaging service users in their own recovery process. Although no participants referred to this process as SDM, their descriptions nevertheless support its operation. On Poppy ward, SDM practices included encouraging service users to take responsibility for their own risk and being supported to become independent through learning practical skills such as cooking and budgeting (see Chapters 5 and 6). This process of empowerment diverges from much of the literature relating to first-hand experiences in the inpatient setting. Independence such as that which appears to occur in Poppy ward suggests an alignment with a recovery principle of gaining independence. As Stickley and Felton (2006) suggest, mental health professionals cannot 'do' or 'provide' recovery; "this is not something that can be 'done' to a person, it is something that users must do for themselves" (Repper, 2000, p. 581).

10.2.2.1 Importance of and Barriers to Collaborative Care. Participants from all phases of the research emphasised the importance of collaborative care, whether this related to decision-making on medication (see Chapter 6); the provision of thorough explanations (see Chapter 9); or best practice involvement (see Chapter 8). The following discussion focuses on an interesting divergence between Poppy service user and staff findings relating to care-planning.

Contrary to much of what has been reported in the literature relating to service users feeling insufficiently involved in care plans (Walsh & Boyle, 2009), at Poppy ward, service users expressed overall satisfaction with care-planning processes: they felt involved and able to direct the care plan. Choice aligns with one of Grundy and colleagues' (2016) identified key features that support meaningful service user involvement in care-planning. This pattern of experience digresses from that reported by Simpson and colleagues' cross-national mixed-methods comparative study on care-planning (2017) who found that service users felt they had not been genuinely involved, particularly relating to risk-planning, despite staff awareness of its importance. Also contrary to the report by Simpson and colleagues (2017), Poppy ward service users expressed finding good utility of care-plans.

An important finding was the difference between Poppy ward staff and service users' experiences of care-planning. While staff also indicated they felt the care-planning process was collaborative and that service users were able to direct care plans, they were less certain about its utility. Staff expressed critical attitudes towards the care-planning as a 'tick box exercise' that offered little added benefit for service users or bearing on the care carried out. This aligns with what has been found previously regarding both staff and service user attitudes towards care-planning: that it is a process that serves the agenda and needs of organisations but that has little to no bearing on the day-to-day lives of service users (Brooks et al., 2018).

Existing research may be helpful in illuminating the apparent disconnect between the perception of staff and service users towards care-planning processes: it may be that for service users and carers, as was found by Bee and colleagues (2015), a high value is ascribed to the relational components of care-planning; this is somewhat backed up by Reid, and colleagues' (2018) finding the process of care planning is equally as helpful for recovery as the care plan's contents. For staff, however, practicing within the DBT framework, or an 'explicit model of care', which otherwise supports staff to feel effective and boosts morale (Bowles et al., 2001), means that care-planning can be perceived to be disjointed from DBT. This may lead to a failure to link care-planning to their overarching philosophy and thus care-

planning becomes a "bureaucratic process with limited scope for clinical engagement or development" (Isobel & Edwards, 2017, p. 88).

10.2.3 Time as an Enabler of Relationships and Engagement

Participants in Streams 1 and 2 (Chapters 5, 6, and 9) spoke of time as an enabler of relationships and service user engagement. Given the year-long admission at Poppy, time was seen as a facilitator. Poppy staff spoke of time allowing opportunities to build relationships while Poppy ward participants spoke of time supporting them and staff to 'figure each other out.' The year-long Poppy admission, although standard by DBT conventions (Rudge et al., 2020), is, however, not always feasible in other non-specialist settings. Flynn and colleagues (2021) reported one of the major challenges of the implementation of DBT in 'real world' settings is lack of time. Given the importance of time spent together as reported by service users and staff more generally (see Chapter 2) and evidence that both higher quality and quantity of time may facilitate staff viewing service users as 'whole people' (Topor & Denhov, 2012), a major factor in the positive experience of Poppy ward may simply be the luxury of time and its facilitation of more therapeutic contact.

Poppy service user participants also spoke of needing the available time to adjust to Poppy's programme, including responsibilities for recovery and risk. Participants from Stream 2's online phase tended also to emphasise time and patience as important for meaningful engagement but this being curtailed given its limited availability. Although time is a recognised barrier to positive experience of inpatient care (see Chapter 2), an implication of the findings here is that beyond building a therapeutic relationship, time is also required for meaningful collaboration (taking time to explain processes, gain trust in a professional's integrity, and generally facilitating the service user's comfort). Although time and patience have been identified as important contributors to person-centred collaboration in mental health care (Bee et al., 2015; Sommerseth & Dysvik, 2008), it is typically entrenched in a wider discussion relating to the therapeutic relationship rather than as key facilitators of collaboration on their own.

10.2.4 Importance of Staff Specialist Knowledge and Education

Another emphasis from each empirical phase was staff training; for Poppy ward participants, this referred to specialist skills and experience with service users with a diagnosis of BPD. Research (Stapleton & Wright, 2019) demonstrates that this is particularly important to avoid stigma-based attitudes towards and subsequent treatment of service users

that may be damaging. Aligning with Bland and colleagues (2007), staff education may support positive attitudes towards service users and support working effectively alongside them. As Bland (2007) indicates and as staff at Poppy ward emphasise, reflective practice and supervision are likely key alongside training.

Poppy ward service users appeared to experience the benefits of staff maintaining their ability to be present and eschew harmful beliefs about behaviours relating to individuals with a diagnosis of BPD. Participants emphasised staff both listening to them and imparting skills in managing their difficulties, in line with Hopkins and colleagues' (2009) findings that inpatient service users' main areas of concern include access to knowledgeable, empathetic staff and Walsh and Boyle's (2009) finding that inpatient service users want information. The finding that service users specifically value a combination of being taught DBT skills alongside being listened to and understood, is an important one that adds nuance to the literature. Participants from the online acceptability phase, practitioners and those with lived experience alike, emphasised ongoing staff support and training to effectively embed the PNM in services; one-off training sessions were not seen as sufficient or likely to lead to meaningful change.

10.2.5 Alternatives Like PNM Could Add Meaning and Coherence

Some participants from Stream 1 and 2 (Chapters 5, 8, and 9) felt the PNM offered a different and valued way to practice. As noted in Chapters 5 and 8, the PNM was contrasted to Poppy's use of the DBT model. While participants valued their existing practices which they also believed to be positively experienced by service users, they nonetheless indicated that narrative and meaning would be appreciated additions for some service users. Participants in the online acceptability phase (Chapter 9) indicated that a more psychosocially based understanding of mental health challenges would also be valuable. These findings appear to align with those reported by the SHIFT Recovery Community (2020), whose members published an article detailing the value of the PTMF in introducing the means to reframe their experiences, which they found empowering and therapeutic. In the UK context, dropout rates from DBT therapy are high (up to 67%; Zinkler et al., 2007) and thus, further investigation into factors that can enhance retention are justified, including the use of narrative.

Poppy ward staff from Chapter 9 also indicated the PNM could also possibly support PRT and add value to the care-planning process. Examples exist relating to the use of formulation to guide service user care and influence the wider culture (see Chapter 7). These

results suggest staff who feel their current processes are of little practical value may consider practices such as the PNM to support theoretical coherence such as that discussed above in Section 10.2.3.

10.2.6 'Selling' the PNM Necessary

Stream 2 participants spoke about the need to 'sell' the PNM (see Chapters 8 and 9), either through emphasising its to benefits to staff, service users, or both. Chapter 9 participants predicted staff resistance and how to manage this, with a focus on inpatient settings. Resistance was described as a natural and inevitable reaction to proposed change and some staff may not be motivated to take it on for various reasons (see Chapter 8).

One practitioner participant described facing such resistance to her attempts to effect change that she felt her job security was at risk. Although this sort of perceived threat has not been widely reported in relation to organisational change literature, certainly discouragement is prevalent, such as that described by Collins (2018), where a staff member was discouraged from taking on what was conceived of as 'extra work' by colleagues but that she (and eventually the Trust) believed provided an enhanced, more ethical service. A similar experience was reported by clinical psychologist participants in Cook, Smythe and Anscombe's (2019) study who felt their proposals of psychosocially based understandings of mental health difficulties led to being ostracised by other professionals, or that they were 'stepping out of line'. Laker and colleagues (2019) offer explanations relating to what factors influence resistance towards change in the acute setting. They found that emotional exhaustion predicted low motivation to take up change, that low confidence was related to higher rates of depersonalisation, and overall, direct care staff expressed more powerlessness.

Allan and colleagues' (2014) findings reported attitudes towards change in the NHS in the context of a restructuring of service delivery. Interestingly, most participants agreed in principle about the need for restructuring but found its imposition distressing given the little control they had over its implementation. It is therefore possibly the means by which change is delivered and how sensitively it is implemented that makes a difference for resistance. Working with Poppy staff more closely to develop the training and implementation may have facilitated greater uptake of this research.

10.2.7 PNM's Strengths Focus Adds Value

The emphasis on positives and strengths throughout the PNM was welcomed by a majority of Stream 2 participants. Practitioners, individuals with lived experience, and those

who identify as both indicated they found it powerful to acknowledge positive aspects of oneself, and to reframe reactions to challenges as adaptive or survival tools. The focus on strengths while acknowledging difficulties was especially remarked on and thought to be helpful, which echoes some of what Poppy ward staff expressed.

In the PNM training sessions, Poppy ward staff flagged the identification of positives and strengths may be laborious with service users diagnosed with BPD; this was echoed in Stream 2 with one participant suggesting a service user with a diagnosis of BPD may find the suggestion of positive qualities as invalidating. This concern is echoed by Walsh and colleagues (2018) whose study on factors that might affect the acceptability of an online positive psychology intervention found that for participants experiencing depression and anxiety, a treatment based on positive psychology could lead to them feeling belittled, misunderstood and dismissed and ultimately discourage their engagement. There was a need for their painful feelings to be validated. The PNM is intended to provide such validation; however, as it has not yet been tested with service users, it is unclear whether this will translate to actual experiences of it.

10.2.8 Risk Presented by Narrative and How to Manage

Participants Stream 2 identified the potential for negative aspects of the PNM. This is unsurprising given the inclusion of past experiences in the Model and the prevalence of trauma, abuse or other painful experiences amongst those who access services. Amongst the few studies exploring service users' experiences of formulation, the literature confirms the potential for formulation (Redhead et al., 2015; Yeandle et al., 2015) and narrative (Robertson et al., 2020) to be distressing. Participants with lived experience from the Stream 2 online phase indicated their willingness to participate in a discussion of past experiences depended on where they were in their recovery journey, specifically if they had the skills to endure the distress that recounting trauma could incur.

Kantor and colleagues (2017) found that trauma survivors (who form a high proportion of those who attend inpatient mental health services) may feel apprehensive about accessing mental health services for the very reason that they wish to avoid reminders of their trauma or about dealing with particular memories during treatment.

10.2.8.1 Risks of Being Pushed Into Particular Narratives. According to the literature, aside from the process of rehashing potential abuse and trauma, formulation can pose the risk of imposing unhelpful (DCP, 2011) or inaccurate messages or narratives (Redhead et al., 2015). Charlesworth (2010) indicated that service users can also feel distressed by the pressured to assign blame to others or perceive they are being framed as weak.

10.2.8.2 Risks of Not Discussing Narrative. This study also found that several participants with lived experience indicated they would have found an exploration of past experiences helpful and regretted being denied this opportunity. Moreover, Elliott and colleagues (2005) indicate that by not talking about past traumas or adverse events, this introduces a risk of re-traumatising service users. They argue that denying individuals the opportunity to discuss past experiences may parallel service users' experiences of being told not to tell anyone about the abuse; imply the service user exaggerated what happened; or that revealing it can make it worse. Staff conveying unwillingness to discuss previous trauma can also effectively limit the therapeutic relationship (White & Morris, 2019). It is important to note that not all service users may wish to disclose or discuss trauma, however (Hodgetts et al., 2007).

10.2.8.3 Staff Reservations Relating to Narrative. The staff who participated in this study indicated a similarly nuanced perspective. Discussion of service users' historical events was noted by Poppy staff in Chapter 8 as possibly problematic due to the potential for uncovering trauma. This was expressed in the PNM training sessions and in the staff focus group. Practitioner participants from Chapter 9 tended to be more open to the discussion of past experiences, including trauma, although this was dependent on the emotional stability and recovery level of service users. Poppy ward staff expressed concern about potentially reintroducing trauma by discussing past experiences, which was thought to possibly exceed some staff's capacity to manage the resultant emotional fallout. This may not be surprising given that according to Bland and colleagues (2007), "treatment staff must keep the patients focused on reality and present all interactions as occurring in the present, not in the past" (p. 207) in relation to working with service users with a diagnosis of BPD. Prominent models used within the NHS include ACT and CBT take on a similar approach, discouraging any 'looking back'.

As explored in Chapter 8, beyond concern for service users' welfare, staff may also be motivated to avoid the subject of possible past traumas due to a lack of confidence in their clinical skills in containing such a conversation or lack the support to maintain their own emotional safety. As Charlesworth (2010) argues, staff may feel overwhelmed by the devastation of service users' life histories which may result in 'paralysis' and a position of 'therapeutic nihilism.'

An awareness of the broader organisational culture that generally discourages staff from taking such a risk may also impact staff willingness to engage with service users regarding their histories. Scott and colleagues (2011) contend that "Western mental health care has shifted from a 'therapeutic consciousness' to risk consciousness" (Felton & Stickley, 2018, p. 55). As argued in Chapter 8, risk averseness and blame culture exists in the NHS and may indirectly impact on staff willingness to ask questions about service users' histories, possibly leading to service user experiences of staff being uninterested in hearing about or integrating an understanding of trauma throughout care (Sweeney & Taggart, 2018).

It is undeniable that engaging service users in conversations relating to past experiences introduces risk. Nonetheless, an unwillingness to explore past experiences to better understand oneself and more effectively plan for the future conveys risk-averseness. Risk averseness has been criticised (Stickley & Felton, 2006) for neglecting to consider the possibility for positive consequences of risk-taking, including growth and healing. As Marsh and Kelly (2018) argue, to deny service users the ability to take risks is to deny them dignity.

As described to Jennifer White (2020) by a service user "I want more to life than just being safe." Supports for narrative or formulation practices were discussed in Chapter 9.

10.3 Conclusion

10.3.1 Aims and Research Questions

This research aimed to first explore the experiences of staff and service users on a positive practice ward to establish how a formulation model could best support and extend this model of care. This informed the development and acceptability testing of a collaboratively developed model of formulation, the PNM.

10.3.1.1 Stream 1. This stream sought to explore the questions, in line with the critical realist case study approach (Easton, 2010):

1. What factors do MDT staff believe are involved in the operation of Poppy ward as a positive-practice specialist ward for service users with a diagnosis of personality disorder?
2. What factors do service users believe are involved in the operation of Poppy ward as a positive-practice specialist ward for service users with a diagnosis of personality disorder?

10.3.1.2 Stream 2. This stream sought to describe the development of the PNM, its acceptability within an applied specialist ward, and explore wider perspectives toward the Model to further develop and validate its acceptability and relevance. This stream asked:

3. What does a model of psychological formulation, collaboratively developed alongside local stakeholders to address their needs, look like?
4. What are specialist inpatient staff views of the PNM and its acceptability? What are the enablers and barriers?
5. What are wider stakeholder (clinicians and/or individuals with lived experience of mental health difficulties) views of the PNM and its acceptability and implementation?

10.3.2 Overall Contribution to Knowledge

Research relating to positive experiences of specialist care for staff and service users in the UK is scarce; this research goes some way to address this. Results confirm that service

users wish to be treated with humanity to positively experience care. Specifically, service users appreciate a sense of community; opportunities to interact with staff casually; to develop good relationships; feel their strengths are supported; and work collaboratively with staff on their care. Service users appreciate individualised care and staff seek to provide this. Results confirm staff and service users should be given the option to understand mental health through a lens that is most helpful for them. The findings relating to the experience of care-planning offer a contrast to the literature (Simpson et al., 2017) as Poppy ward staff and service users diverge somewhat in their experiences of care-planning where staff were critical of care-planning and viewed it as a 'tick box exercise.'

One of the first models of psychological formulation to be developed collaboratively, the results indicate the PNM supports positive care by addressing aspects deemed important by service users and staff alike and has the potential to add meaning to care-planning. The PNM offers a way of supporting collaborative care-planning and formulation and supports the development of therapeutic relationships through an improved understanding. These features were deemed acceptable by participants in Stream 2 and much of the feedback relating to barriers and enablers overlapped in the studies, which offers insight for future researchers and application in other settings. Possible challenges of implementing the PNM are identified as well as ways to address them.

10.3.3 Stream 1

Positive practice or 'what works' is not often explored in research (Acford & Davies, 2019), particularly within specialist inpatient services for service users with a diagnosis of BPD; thus, this thesis offers a contribution to knowledge through a focus on positive practice within such an environment. The findings of overall positive experiences, particularly for service users, diverge from previous research suggesting a higher prevalence of negative experiences of treatment for service users with a diagnosis of BPD in the UK (Stapleton & Wright, 2019).

This thesis also addresses the scarcity of research into the application of SDM and PRT in an acute setting (Beyene et al., 2018; Just et al., 2021). This research examines the perspectives of staff and service users who work and live on a ward that implements both SDM and PRT. Both groups reported shared responsibility for risk, recovery, and decision-making related to care. An important illustration of shared decision-making on this ward was the example of service users feeling they had a meaningful influence regarding their

medication, an area of decision-making that typically remains within the remit of psychiatrists (Slade, 2017). Service users generally indicated they felt staff engaged with them in a truly collaborative way, demonstrating the challenges in implementing PRT described in the literature can be addressed successfully (Just et al., 2021). These findings serve to illustrate conditions that sustain these practices in this particular applied setting (Gravel et al., 2006; Perestelo-Perez et al., 2011), including interpersonal relationships, the structured DBT modality, and a focus on continuing staff education.

Results from this research reinforce the importance of relationships for staff and service users. The importance of relationships has been well documented; however, this research found unexpected features of relationships between staff and service users as well as between service users. Staff and service users spoke of a lack of separation between them as groups as well as a 'flattened hierarchy' which while arguably not truly achievable in the inpatient setting, is a perception that has been spoken of as a goal by existing research (Elliott et al., 2005). Again, both staff and service users spoke of having generally good relationships with others on the ward as well as a sense of community. Staff and service users spoke of time and activities spent together, which seemed to help build a sense of community and familiarity not described elsewhere in the literature. In contrast with existing literature which indicates a peer support structure can naturally occur (Galloway & Pistrang, 2019), while service users tended to speak of their peers positively, they also intimated clearly defined boundaries relating to sharing their difficulties so as to avoid 'triggering' others.

While previous research has emphasised staff knowledge and understanding of BPD due to its lack, this research confirms the presence of staff specialist training and knowledge are key for positive experiences of care for staff and service users. In this research, both groups emphasised knowledge of BPD and DBT in explaining positive experiences of care. Service users indicated that staff specialist knowledge averts the use of restraint via the encouragement of the use of DBT skills to manage the distress that may otherwise lead to the use of restraint. Interestingly, service users indicated that talking to or being listened to by staff by itself is limited compared to its combination with being taught skills. Staff emphasised both ongoing staff training as well as the DBT structure involving staff consultations and reflective practice.

An important finding was that while Poppy ward service users were, on the whole, pleased with the care-planning process, staff were more critical. This is possibly due to the role care-planning plays for both staff and service users. For staff who participated in this research, echoing that reported elsewhere, it is a largely bureaucratic process (as Brandon and

Christopher indicated) for the purpose of audits while service users valued the opportunity to track and have a record of their progress. Research has also indicated care-planning can be a valued way to spend therapeutic one-on-one time with staff, which may also at least partially explain these positive experiences. A possible explanation from previous literature (Isobel & Edwards, 2017) is that theoretical alignment may be important for mental health staff, particularly for those whose organisations employ structured modalities such as DBT. For staff, the disconnect between care-planning with its absence of alignment with DBT results in frustration, with care-planning feeling meaningless as a result. For service users, alignment with the DBT model does not appear as consequential; service users in this study reported satisfaction with existing care-planning practices, the only suggestion for improvement related to its timing.

10.3.4 Stream 2

The PNM presents a contribution to knowledge as, to my knowledge, it is one of the first models of formulation collaboratively developed alongside individuals with lived experience of mental health difficulties (as well as through consultation with published models, local practitioners, and my supervisory team). The only known exception is the 'guided formulation' model, the development of which authors indicated staff and service user feedback was sought but no further details provided (Yeandle et al., 2015). An iterative process resulted in the development of the final version of the PNM. The collaborative approach to Model development taken in this research sought to enhance the relevance and acceptability of the Model by grounding its features as closely as possible to the reality of service users' experiences while observing stakeholder-reported parameters of services, minimising the risk of shoehorning stakeholder realities to conform to model developed based on theory alone (Spandler, 2021). Collaborating with the SUAG ensured service user perspectives and priorities were considered and provided an opportunity to ensure commonly encountered pitfalls were avoided and positive features of services supported. Given the Model is intended to be used transparently and collaboratively, this was paramount.

There is little research relating to service user perspectives or experiences of psychological formulation. While this research did not investigate the first-hand experience of formulation practices, lived experience perspectives of the PNM itself as well as its acceptability add a valuable contribution to knowledge. Equally, staff perspectives relating to the acceptability of this Model with its focus on psychosocial influences adds an important

contribution to knowledge. The PNM was acceptable overall, with particularly favourable responses from online participants, 100% of whom indicated they found the PNM 'acceptable' or 'very acceptable'.

Results from this research indicate the PNM may be perceived as a support to both SDM and PRT practices. Participants, particularly the online participants, reported favourable attitudes regarding the collaborative nature of the PNM and its position of valuing both staff and service user perspectives and expertise. Poppy ward staff indicated the use of the PNM may facilitate better knowledge and understanding of service users, thus supporting PRT on both an evidential and emotional basis.

The aspects of the PNM that were highly valued by both service user and practitioner participants generally were those that the SUAG as well as the practitioners consulted during the Model development process emphasised, confirming the value of stakeholder consultation in addressing the needs of end-users. For example, the focus on strengths and positive aspects and their inclusion throughout the various aspects of the PNM (for example, viewing threat responses as a survival tool and thus a positive) was highly appreciated and indicates that although strengths-based models do exist, they may not be implemented or integrated extensively in services.

The results of this research offer key lessons relating to possible challenges in implementing the PNM or other models of formulation within acute inpatient settings, as well as suggestions to manage them. Challenges expressed by staff in the online phase overlap significantly with those expressed by Poppy ward staff. For example, Stream 2 participants spoke of the need to support the implementation of a new Model such as the PNM on an ongoing basis to effectively embed it within everyday practice, as well as the need to 'sell' it to staff.

An important and unexpected finding related to attitudes towards the risk presented by asking service users about their past, which was expressed by Poppy ward staff and echoed by both participants with lived experience and professionals in the online acceptability phase relates to the risk of distress posed by the development of narrative. These perspectives are explored and interpreted in the context of wider literature relating to the risks posed by formulation practices as well as organisational risk-averseness. Possible supports and considerations are offered.

10.3.5 Practical Contribution

The difficulties implementing the staff training as well as the PNM itself within Poppy ward's inpatient setting offers key considerations for future doctoral-scale research, including accounting for staff rotas, possibly offering additional resources, such as an online series of videos, documents, or examples to be made available to all staff in advance and after more in-depth training sessions. In addition, given the continuing need for physical distancing due to COVID-19, future training strategies could possibly make use of digital technologies such as online training modules to supplement in-person training.

Qualitative feedback relating to training on psychological formulation has not been covered extensively in the literature. This research provides a valuable insight into what factors staff value in training as well as their perspectives relating to strategies to embed the model into everyday practice. Suggestions from Stream 2 qualitative and quantitative surveys alongside interviews additionally indicate that organisational factors can play a large part in the success of implementation. For example, it was viewed as essential to secure managerial support for a new practice such as the PNM. Although this research did have managerial support and data indicates staff, on the whole, found the PNM acceptable, Stream 2 qualitative results indicate that other static factors such as the overburden of staff means that change happens very slowly and requires more resources than were available to this project.

Many Poppy staff who participated in the research had not been exposed to formulation. Feedback was that it was 'too much too soon' for staff unfamiliar with these practices and given the difficulty for staff to consistently attend sessions that may have familiarised them with the concepts, it was understandable that staff did not report having applied the PNM. Buchanan and Shocolinsky-Dwyer (2016) offer ways to maximise the time spent training staff by first consulting them regarding what they wanted to learn about formulation. Doing so in this research may have led to further training sessions or further resources introducing the basics of formulation more extensively, which staff reported would be required (see Chapters 8 and 9). Buchanan and Shocolinsky-Dwyer (2016) also recommend that, if possible, a facilitator should be part of a staff team to reinforce the content in variety of contexts. This was not possible in this thesis; however, future research should take this into consideration as it likely would have been helpful. Sturmey and McMurran (2019) further recommended teaching formulation skills at an individual pace, which while incompatible with traditional group training sessions, likely would yield a superior understanding.

10.3.6 Methodological Contribution

Despite the challenges of doing so with the limited resources available, the inclusion of the SUAG throughout this research (including ad hoc contributions before the SUAG proper was assembled) demonstrates the feasibility of meaningful involvement in research of this nature and scale. Although the SUAG itself was comprised of only three members during the development of the Model and two during the analysis and write-up of the data, the insight and critical feedback was invaluable in ensuring the relevance of the research, particularly given my 'outsider' status as a researcher.

The SUAG's involvement during the analysis phase involved a combination of approaches 2 and 4 of the 'collaborative data analysis' (CDA) framework (Jennings et al., 2018) involving training and coding of all six service user interviews transcripts. The SUAG's contributions added immeasurable value and often challenged my own interpretation of the data, adding a depth and richness to the analysis I could not have accomplished by myself. Their feedback being included throughout the Chapter 8 results, supported by the critical realist framework, also presents a form of methodological innovation.

The case study of Poppy ward involving both staff and service user views aligns with the overall critical realist framework adopted for this research. By investigating the question of 'what factors sustain Poppy ward's positive practice?' from multiple perspectives and identities, a closer depiction of 'reality' was arguably attained.

Relating to Stream 2's online phase of data collection, while Braun and colleagues (2020) argue that interviews in addition to qualitative surveys require the provision of a rationale, it is also the case that there are key drawbacks to online surveys that are addressed by interviews. For example, space and time restrictions may reduce the ability to convey nuance in a way I felt the interviews enabled. I was able to follow-up with questions directly as well as develop the rapport deemed important to rich data collection. I also found the interviews were longer during the online phase, probably at least somewhat due to participants generally being interviewed in the comfort of their homes and with the added control of being able to close our online video chat at their discretion entirely (no participants took advantage of this option).

10.3.7 Limitations

This research has several limitations. The final design, as a consequence of the need to conform to Poppy ward's capacity, meant there were no longer term outcome measures. Service users did not undergo formulation sessions due to the absence of a clinical psychologist on the ward to facilitate individual formulation sessions, which limits conclusions relating to the PNM's acceptability to service users.

I, the researcher, conducted the training; I also collected feedback questionnaires, facilitated the focus group, and conducted the interviews. Despite attempts to reassure participants that regardless of the content of the feedback that this would not impact on how I viewed them, this was not likely sufficiently reassuring. While it would have been preferable for a neutral third party to disseminate questionnaires or facilitate the focus group, as the research took place on an NHS inpatient site, coordinating access via the relevant channels would have been cumbersome and beyond the already stretched timeframe.

That participants from the Poppy ward staff focus group and online acceptability phases were self-selected may have had an impact on the findings is also a possibility. Poppy ward staff who attended the training may have had especially good or poor experiences of the training and were motivated to share; may have been more eager to attend professional development sessions or research in general; or had any other conceivable agenda that favoured a particular response, is a possibility. Those who participated in the online research may have had similar motivations, either desiring to express either decidedly positive or negative views.

The sample sizes of each phase of this research would be considered small for Braun and Clarke's RTA (Braun & Clarke, 2019a), which was used to analyse the results. While saturation was not the goal of the analysis as this is incompatible with the 'big Q' orientation of this research (Braun & Clarke, 2020), given the reflexive approach taken, a higher number of participants would have provided a broader perspective and likely added more nuance. For example, many of the instances of barriers or points counter to the dominant positive narrative relating to Poppy ward's operation were articulated infrequently and therefore are not richly explored. Additional or lengthier interviews could have remedied this. That these dissenting opinions were often voiced by more senior members of staff is difficult to interpret. It may be these staff members felt more secure in voicing critique or they are privy to a more distant view of operations and therefore have a broader perspective.

Interviews with Poppy staff and service users were relatively short due to time restrictions, although on par with Summers (2006), whose study on psychological

formulation in the acute setting involved interviews that lasted up to 20 minutes and others, including Boardman and colleagues' (2018) interviews with HCAs that lasted between 15 and 45 minutes and Galloway and Pistrang's (2019) interviews with service users and staff that raged from 30 to 80 minutes (Galloway & Pistrang, 2019). Although most interview questions were asked and answered within this time, the brevity of the interviews were likely at least somewhat explained by the pressurised environmental cues (interviews took place on the ward) and likely had an impact on the depth or richness of responses. Again, given the interviews took place on the ward due to convenience for staff being interviewed in the same setting where they worked may have impacted on their willingness to give critical answers, regardless of the interviews taking place in a private room.

A limitation of the Chapter 6 analysis was identified by the SUAG: I neglected to include the length of time each service user had been on the ward at the time of the interview in the demographic questionnaire. This may have been helpful in interpreting particular findings, such as whether length of time on the ward may have impacted service user reluctance to speak to staff (a noted phenomenon; Fox et al., 2001); however, amending the ethics application to secure this information would have been prohibitively time-consuming.

The participant sample recruited to the study was overall small and homogeneous, with most participants identifying or presenting as white. Within particular phases of the research, this homogeneity was marked: service user participants in the interviews were all female and all white. Poppy ward staff participants were overwhelmingly white and mostly female, while almost all participants in the online acceptability phase were female. The SUAG recruited for this study was also white and female, as am I. The absence of racialised identities or individuals with non-white backgrounds in developing and exploring the PNM begs the question, "if research is done by white people on white people, then how relevant is it to people of colour?" (Faulkner, 2020, 18:45). The PNM's applicability to non-white persons has yet to be evaluated and would require review by people with a wider range of experiences and race identities to ensure its relevance. The homogeneity of the sample also may have led to a culturally uncritical discussion and development of themes (Gilburt et al., 2008; Woods & Alsawy, 2016).

As outlined in Section 10.3.5, due to the nature of the inpatient ward rota and the limited time available to collect data, the training was not implemented as intended (see Chapter 7), with no staff members able to attend all four training sessions and most attending one or two sessions. The logistical difficulties of (a) training all ward staff; and (b) coordinating the training session so the same members of the staff team could attend all four

sessions were unanticipated. While I discussed means of ensuring interested staff members had the opportunity to attend sessions they had missed and the ward manager indicated her approval for these to be conducted individually through direct arrangement of the staff, the data collection schedule timing prohibited this. Future research should heed these results as well as the advice from Buchanan and Shocolinskiy-Dwyer (2016) relating to adapting to staff rotas and anticipating the logistical difficulty of training staff.

An expert by experience was also originally recruited to co-facilitate the staff training at an earlier stage of the research (see Appendix A); however, due to personal circumstances, this was not possible and the training that went ahead did not allow sufficient time for this to be arranged. Future research should prioritise this both to ensure the perspectives of those with lived experience in applying the Model are conveyed as well as per participant feedback relating to the need for further service user input or testimony. In a similar vein, although it was recommended by the SUAG for an advocate affiliated with the Trust to be recruited as a co-interviewer to enhance data quality, this was beyond the scope of this research. This would have undoubtedly enhanced the rigour of the research process, given the presence of a peer may have elicited more honest, rich interactions (Gillard et al., 2010). During interviews with service users, the influence of a peer could also have enhanced the sensitivity of the direction of the interview. As it was, the interviews with service users were relatively short and there remains the possibility that a co-interviewer with perceived peer status may have acted to encourage discussion and sharing.

10.3.8 Implications for Mental Health Services and Practice

Given Poppy's success in facilitating reports of high satisfaction in experience of the ward for both staff and service users, some of the concrete practices described the Poppy ward model may be operationalised on similar wards. For example, support for PRT and SDM appeared to occur through staff training on BPD, time spent together as a community, not searching service users, and preferring to accept voluntary service users. Some of these practices are more resource-intensive than others. Bills and Bloom (1998) found in their transformation of a specialist ward 'from chaos to sanctuary' that cultural transformations generally do not "require fancy techniques or expensive equipment, but rather a change at the level of system norms" (Bills & Bloom, 1998, p. 7). For example, it is possible that particular practices such as meals together, games between staff and service users, and discharged service users being invited back for weekly social hours (pre-COVID-19) creates the

conditions that allow for better relationships. These simple and low-resource activities may improve service users' perception of being treated with humanity, as equals.

These results also emphasise the importance of offering service users the option to explore their past and develop a narrative. Not all service users will wish to do so, and some service users will be best served by services as they currently exist. However, as argued above, denying service users who wish to understand themselves through the lens of previous events and how they currently affect them to move forward can lead to frustration at best and re-traumatisation at worst. Supporting staff to feel more comfortable to engage in this work, particularly that related to service users recounting trauma, is an important consideration but one in line with the call for trauma-informed services.

The frustration experienced by staff relating to the bureaucratic, restrictive and therefore largely ineffective care- and risk-planning process defined by its 'box-ticking' approach aligns with the frustration expressed by White and Morrison (2019) relating to narrow, medicalised risk-assessment protocols that they feel can be limiting, damaging or even unethical in their denial of the humanity and complexity of individual circumstances. The move towards offering the option of a more person-centred, narrative-based approach was seen by these authors as an ethical imperative to both these authors and the participants in this study who expressed concern and wanted to offer a more individualised approach to treatment.

10.3.9 Future Research

The findings from this research present a foundation from which future research can proceed. The first relates to investigating whether a separate formulation approach is warranted for service users with a diagnosis of BPD. The PNM was developed based on the DCP good practice formulation guidelines (2011) relating to formulating based on an individual, not their diagnosis; in a similar vein, in a Delphi survey of specialist professionals, Brown and Völlm (2013) concluded any evidence-based model of formulation could be used, regardless of its theoretical model or whether it is integrative. However, formulation models have nonetheless been developed specifically for this population (Yeandle et al., 2015) and adaptations specifically for service users with a diagnosis of BPD were suggested research by participants in this research. Future research could investigate this apparent disconnect (see also Wagner et al., 2007).

Future research could investigate the PNM from an inpatient service user perspective as well as evaluate outcomes related its implementation. This would add to the body of literature regarding service users' experience of formulation more generally, which is currently lacking (Evans, 2020).

Jones and colleagues' (2018) systematic meta-narrative of the literature relating to mental health care planning and care coordination found an increasing trend for best practice ideals to be subverted by top-down organisational agendas, resulting in staff cynicism, particularly towards care-planning (Simpson et al., 2017) and which is echoed in this research. Given the results of this research suggest the PNM or other more narrative-based models may enhance the value of care-planning for staff specifically, future researchers may wish to investigate this further, particularly given the need for research to continue to investigate means to make care practices more individually responsive and to enhance the planning and coordination of services (Jones et al., 2018). The findings in this study indicate the absence of theoretical or conceptual alignment between the ward's overall modality (DBT) and care-planning may create a disconnect which results in the perception of care-planning as lacking meaning. Future research could investigate the value for staff, perhaps with an index of satisfaction, of using a more theoretically coherent formulation approach to provide intellectual scaffolding for the care-planning process.

The major area staff felt could be improved relates to the CQC's care-planning guidelines, which result in onerous, lengthy, and ultimately unhelpful documents. Staff feel the very guidelines in place to ensure person-centred care, in fact, hinder this very goal, echoing recent findings from other UK-based staff (Drummond & Simpson, 2017). This aligns with the need for 'user friendly documentation' identified by nurses in Anthony and Crawford's (2000) study on service users' involvement in care planning, and which echoes Drummond and Simpson's (2017) findings of the need for more streamlined, accessible documentation for staff, who suggest frontline staff should be involved in improving existing documentation protocols and electronic recording systems. Future research could support and evaluate such an undertaking.

In line with Robertson (2018) and Griffiths (2019), views from participants in this thesis indicated that developing narratives may introduce significant distress. Future research could help to develop a deeper understanding of the possible distress and risks involved in formulation as well as what sorts of support should be available in various settings for both staff and service users (see Robertson, 2018 and Griffiths, 2019 for suggestions relating to peer support workshops).

Similarly, future research may investigate how best to support staff, particularly HCAs or other staff who are not formally trained, to discuss adverse events or trauma with service users. It is likely that even if these staff members are not expected within their roles to undertake these types of conversations, they may occur naturally as a result of the time they spend with service users and the nature of their relationship. There is a strong possibility that learning basic skills such as containment or validation will be useful to prevent secondary traumatisation or other negative impacts should a service user disclose adverse events.

Despite overall being reported as accessible and clear, a subset of Stream 2 participants indicated that for service users who are highly distressed or are experiencing depleted cognitive resources, that a more clear version of the PNM should be made available. Future research could investigate what this might look like.

The PNM was developed alongside contributors from a homogenous, white, primarily female group. Further consultation with service users from a wider range of cultural backgrounds and racialised identities is required to ensure that the PNM addresses wider cultural needs and incorporates feedback from a more diverse array of perspectives. The acceptability of the PNM would also need to be reassessed with these populations.

10.3.10 Reflection

This research is ultimately about humane care and the promotion of positive practices through the empowerment of staff and service users alike. However, the topic of power in its less positive form underlies much of how we talk about mental health, research on mental health, and the provision of mental health services. I would be remiss if I did not address how it operated within this PhD. At various points of this research journey, being without credentials or possessing the right to access the ward setting where this research took place, I felt I was in a position of relative powerlessness, or at least at the mercy of gatekeepers. However, as this research has been guided by principles of coproduction and involved a SUAG, I have also been in positions of relatively higher power or authority. I have had veto power in terms of how the research is conducted, what suggestions for change to take more seriously or to implement, how often we met, and what the final product looked like. Despite my attempts to take a more egalitarian approach, I am aware that my own biases and agendas are likely woven throughout this work. In the future, I will ensure a more egalitarian approach is taken.

Like this thesis, my worldview has evolved throughout the past several years. As I stated in Chapter 1, I began this PhD as uncritically and unreflexively indoctrinated in the 'DSM mindset'. Very quickly, however, through exposure to the concept of personal recovery and the works of critical researchers, professionals, and most importantly, individuals with lived experience, I began to question conventional understandings of 'mental illness.' I was soon converted to the alternative 'side' of the debate. It was within this frame of mind that I began the applied phase of my research. My interactions with professionals and service users in the applied setting then exposed me to how ideologies can coexist 'on the ground'; this wider range of non-binary perspectives led to my own shift in understanding. Seeing recovery, SDM, and PRT practices as well as positive relationships, dignity, and warmth in a service ostensibly predicated on psychiatric diagnosis and operating within a fundamentally coercive system (inpatient services) forced me to re-examine my assumptions once again. Resisting the temptation of conceptualising mental health and ways of understanding it as dichotomous, I now endeavour to embrace the complexity of apparently contradictory ways of understanding, working, and operating. As is advocated by the critical realist paradigm, integrating and evaluating as many perspectives as possible supports a better understanding of reality and equips us with a clearer roadmap for change. I believe the more we are able to accommodate nuance, individuality, and difference, the more humane services and our society can be.

References

Abma, T. A., Nierse, C. J., & Widdershoven, G. A. (2009). Patients as partners in responsive research: Methodological notions for collaborations in mixed research teams. *Qualitative Health Research*, *19*(3), 401-415.

Acford, E., & Davies, J. (2019). Exploring therapeutic engagement with individuals with a diagnosis of personality disorder in acute psychiatric inpatient settings: A nursing team perspective. *International Journal of Mental Health Nursing*, *28*(5), 1176-1185.

Agenda, 2017. *A Briefing Document on the Use of Restraint Against Women and Girls March 2017.* https://weareagenda.org/wp-content/uploads/2017/03/Restraint-FOI-research-briefing-FINAL1.pdf

Aguilera-Serrano, C., Guzman-Parra, J., Garcia-Sanchez, J. A., Moreno-Küstner, B., & Mayoral-Cleries, F. (2018). Variables associated with the subjective experience of coercive measures in psychiatric inpatients: A systematic review. *The Canadian Journal of Psychiatry*, *63*(2), 129-144.

Aherne, C., Moloney, O., & O'Brien, G. (2019). Youth Mental Health and the Power Threat Meaning Framework: Jigsaw's systems perspective. *Number 313–January 2019*, *313*, 3.

Ahmed, S. M., & Palermo, A. G. S. (2010). Community engagement in research: Frameworks for education and peer review. *American Journal of Public Health*, *100*(8), 1380-1387.

Akther, S. F., Molyneaux, E., Stuart, R., Johnson, S., Simpson, A., & Oram, S. (2019). Patients' experiences of assessment and detention under mental health legislation: Systematic review and qualitative meta-synthesis. *BJPsych Open*, *5*(3).

Allan, H. T., Brearley, S., Byng, R., Christian, S., Clayton, J., Mackintosh, Price, L., Smith, P., & Ross, F. (2014). People and teams matter in organizational change: Professionals' and managers' experiences of changing governance and incentives in primary care. *Health Services Research*, *49*(1), 93-112.

Allen-Meares, P., Hudgins, C. A., Engberg, M. E., & Lessnau, B. (2005). Using a collaboratory model to translate social work research into practice and policy. *Research on Social Work Practice*, *15*(1), 29-40.

Anthony, P., & Crawford, P. (2000). Service user involvement in care planning: The mental health nurse's perspective. *Journal of Psychiatric and Mental Health Nursing*, *7*(5), 425-434.

Archer, M., Bhaskar, R., Collier, A., Lawson, T., & Norrie, A. (2013). *Critical realism: Essential readings*. Routledge.

Archer, M., Decoteau, C., Gorski, P., Little, D., Porpora, D., Rutzou, T., Smith, C., Steinmetz, G., & Vandenberghe, F. (2016). What is critical realism? Perspectives: A Newsletter of the ASA Theory Section, Fall 2017. Retrieved from: http://www.asatheory.org/current-newsletter-online/what-is-critical-realism

Archer, M., Lau, Y., & Sethi, F. (2016). Women in acute psychiatric units, their characteristics and needs: A review. *BJPsych bulletin*, *40*(5), 266-272.

Bacha, K., Hanley, T., & Winter, L. A. (2019). 'Like a human being, I was an equal, I wasn't just a patient': Service users' perspectives on their experiences of relationships with staff in mental health services. *Psychology and Psychotherapy: Theory, Research and Practice*, *93*(2), 367-386.

Baker, J., Sanderson, A., Challen, K., & Price, O. (2014). Acute inpatient care in the UK. Part 1: Recovery-oriented wards. *Mental Health Practice*, *17*(10).

Barber, R., Beresford, P., Boote, J., Cooper, C., & Faulkner, A. (2011). Evaluating the impact of service user involvement on research: A prospective case study. *International Journal of Consumer Studies*, *35*(6), 609-615.

Beck, U. (1999). World risk society: *Polity Press*, Cambridge.

Bee, P., Brooks, H., Fraser, C., & Lovell, K. (2015). Professional perspectives on service user and carer involvement in mental health care planning: A qualitative study. *International Journal of Nursing Studies*, *52*(12), 1834-1845.

Bee, P., Playle, J., Lovell, K., Barnes, P., Gray, R., & Keeley, P. (2008). Service user views and expectations of UK-registered mental health nurses: A systematic review of empirical research. *International Journal of Nursing Studies*, *45*(3), 442-457.

Bee, P., Price, O., Baker, J., & Lovell, K. (2015). Systematic synthesis of barriers and facilitators to service user-led care planning. *The British Journal of Psychiatry*, *207*(2), 104-114.

Bee, P. E., Richards, D. A., Loftus, S. J., Baker, J. A., Bailey, L., Lovell, K., Woods, P., & Cox, D. (2006). Mapping nursing activity in acute inpatient mental healthcare settings. *Journal of Mental Health*, *15*(2), 217-226.

Bensa, S., & Gregg-Rowbury, L. (2016). Staff psychological formulation training in adult services. *British Journal of Mental Health Nursing*, *5*(6), 270-273.

Beresford, P., & Russo, J. (2016). Supporting the sustainability of Mad Studies and preventing its co-option. *Disability & Society*, *31*(2), 270-274.

Bergman, B., & Eckerdal, A. (2000). Professional skills and frame of work organization in managing borderline personality disorder: Shared philosophy or ambivalence—a qualitative study from the view of caregivers. *Scandinavian Journal of Caring Sciences*, *14*(4), 245-252.

Berry, K., Gregg, L., Vasconcelos e Sa, D. V., Haddock, G., & Barrowclough, C. (2012). Staff–patient relationships and outcomes in schizophrenia: The role of staff attributions. *Behaviour Research and Therapy*, *50*(3), 210-214.

Berry, K., Haddock, G., Kellett, S., Roberts, C., Drake, R., & Barrowclough, C. (2016). Feasibility of a ward-based psychological intervention to improve staff and patient relationships in psychiatric rehabilitation settings. *British Journal of Clinical Psychology*, *55*(3), 236-252.

Beryl, R., & Völlm, B. (2018). Attitudes to personality disorder of staff working in high-security and medium-security hospitals. *Personality and Mental Health*, *12*(1), 25-37.

Berzins, K., Baker, J., Brown, M., & Lawton, R. (2018). A cross-sectional survey of mental health service users', carers' and professionals' priorities for patient safety in the United Kingdom. *Health Expectations*, *21*(6), 1085-1094.

Berzins, K., Baker, J., Louch, G., & Albutt, A. (2020). A qualitative exploration of mental health service user and carer perspectives on safety issues in UK mental health services. *Health Expectations*, *23*(3), 549-561.

Beyene, L. S., Severinsson, E., Hansen, B. S., & Rørtveit, K. (2018). Shared decision-making—Balancing between power and responsibility as mental health-care professionals in a therapeutic milieu. *SAGE Open Nursing*, *4*, 2377960817752159.

Bhaskar, R. (1998). Philosophy and scientific realism. *Critical realism: Essential readings*, 16-47.

Bills, L. J., & Bloom, S. (1998). FROM CHAOS TO SANCTUARY: Trauma-Based Treatment for Women in a State Hospital System.

Bladon, H. (2019). Avoiding paternalism. *Issues in Mental Health Nursing*, *40*(7), 579-584.

Bland, A. R., Tudor, G., & McNeil Whitehouse, D. (2007). Nursing care of inpatients with borderline personality disorder. *Perspectives in Psychiatric Care*, *43*(4), 204-212.

Blee, T. A. (2015). *Community mental health team members' perceptions of team formulation in practice* (Doctoral dissertation, University of Lincoln).

Bliss, E. V. (2014). Solution focused formulations. *InterAction-The Journal of Solution Focus in Organisations*, *6*(2), 8-22.

Boardman, S., Clarbour, J., & Rayner, K. (2018). Healthcare assistants' experiences on forensic mental health wards. *Journal of Forensic Practice*, *20*(3), 191-201.

Borschmann, R., Trevillion, K., Henderson, R. C., Rose, D., Szmukler, G., & Moran, P. (2014). Advance statements for borderline personality disorder: A qualitative study of future crisis treatment preferences. *Psychiatric Services*, *65*(6), 802-807.

Border, R., Johnson, E., Evans, L., Smolen, A., Berley, N., Sullivan, P., & Keller, M.. (2019). No support for historical candidate gene or candidate gene-by-interaction hypotheses for major depression across multiple large samples. *American Journal of Psychiatry, 176*(5), 376–387. https://doi.org/10.1176/appi.ajp.2018.18070881.

Bouchard, L., Montreuil, M., & Gros, C. (2010). Peer support among inpatients in an adult mental health setting. *Issues in Mental Health Nursing*, *31*(9), 589-598.

Bowen, M. (2013). Borderline personality disorder: clinicians' accounts of good practice. *Journal of psychiatric and mental health nursing*, *20*(6), 491-498.

Bowers, L., Alexander, J., Bilgin, H., Botha, M., Dack, C., James, K., Jarrett, M., Jeffery, D., Nijman, H., Owitt, J. A., Papadopoulos, C., Ross, J., Wright, S., & Stewart, D. (2014). Safewards: The empirical basis of the model and a critical appraisal. *Journal of Psychiatric and Mental Health Nursing, 21*(4), 354–364.

Bowers, L., James, K., Quirk, A., Simpson, A., Stewart, D., & Hodsoll, J. (2015). Reducing conflict and containment rates on acute psychiatric wards: The Safewards cluster randomised controlled trial. *International journal of nursing studies*, *52*(9), 1412-1422.

Bowers, L., Simpson, A., Alexander, J., Hackney, D., Nijman, H., Grange, A., & Warren, J. (2005). The nature and purpose of acute psychiatric wards: The Tompkins Acute Ward Study. *Journal of Mental Health*, *14*(6), 625-635.

Bowles, N., Mackintosh, C., & Torn, A. (2001). Nurses' communication skills: An evaluation of the impact of solution-focused communication training. *Journal of Advanced Nursing*, *36*(3), 347-354.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in Psychology*, *3*(2), 77-101.

Braun, V., & Clarke, V. (2019a). Answers to frequently asked questions about thematic analysis. *Retrieved from The University of Auckland website https://cdn.auckland.ac.nz/assets/psych/about/our-research/documents/Answers%20to%20frequently%20asked%20questions%20about%20thematic%20analysis%20April%202019.pdf*

Braun, V., & Clarke, V. (2019b). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health*, 1-16.

Braun, V., & Clarke, V. (2020). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*, 1-25.

Braun, V., Clarke, V., Boulton, E., Davey, L., & McEvoy, C. (2020). The online survey as a qualitative research tool. *International Journal of Social Research Methodology*, 1-14.

Breen, R. L. (2006). A practical guide to focus-group research. *Journal of Geography in Higher Education*, *30*(3), 463-475.

Brooker, C. G., Tocque, K., Brown, M., & Kennedy, A. (2016). Sexual violence and abuse and the care programme approach. *The British Journal of Psychiatry*, *209*(5), 359-360.

Brooker, C., Tocque, K., Kennedy, A., & Brown, M. (2016). The care programme approach, sexual violence and clinical practice in mental health. *Journal of forensic and legal medicine*, *43*, 97-101.

Brooks, H. L., Lovell, K., Bee, P., Sanders, C., & Rogers, A. (2018). Is it time to abandon care planning in mental health services? A qualitative study exploring the views of professionals, service users and carers. *Health Expectations*, *21*(3), 597-605.

Brown, M. (2018, August 20). *Challenging narratives: What is The Power Threat Meaning Framework?* Mental Health Today. https://www.mentalhealthtoday.co.uk/blog/diagnosis/challenging-narratives-the-power-threat-meaning-framework

Brown, S., Beeley, C., Patel, G., & Völlm, B. (2018). Training probation officers in case formulation for personality disordered offenders. *Criminal Behaviour and Mental Health*, *28*(1), 50-60.

Brown, P., Calnan, M., Scrivener, A., & Szmukler, G. (2009). Trust in mental health services: A neglected concept. *Journal of Mental Health*, *18*(5), 449-458.

Brown, S., & Völlm, B. (2013). Case formulation in personality disordered offenders: Views from the front line. *Criminal Behaviour and Mental Health*, *23*(4), 263-273.

Bruch, M. (2015). *Beyond diagnosis: Case formulation in cognitive behavioural therapy*. John Wiley & Sons.

Buchanan, S., Shocolinsky-Dwyer, R. (2016). The development, delivery and evaluation of a year-long skills and formulation training programme in a community residential rehabilitation setting. *Clinical Psychology Forum*, *288*, 34-38.

Budd, R., & Hughes, I. (2009). The Dodo Bird Verdict—controversial, inevitable and important: a commentary on 30 years of meta-analyses. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice*, *16*(6), 510-522.

Bullock, J., Whiteley, C., Moakes, K., Clarke, I., & Riches, S. (2021). Single-session Comprehend, Cope, and Connect intervention in acute and crisis psychology: A feasibility and acceptability study. *Clinical Psychology & Psychotherapy*, *28*(1), 219-225.

Butler, G. (1998). Clinical formulation. In A.S. Bellack & M. Hersen (Eds.), *Comprehensive clinical psychology.* Oxford: Pergamon.

Cahill, J., Paley, G., & Hardy, G. (2013). What do patients find helpful in psychotherapy? Implications for the therapeutic relationship in mental health nursing. *Journal of Psychiatric and Mental Health Nursing*, *20*(9), 782-791.

Cameron, D., Kapur, R., & Campbell, P. (2005). Releasing the therapeutic potential of the psychiatric nurse: A human relations perspective of the nurse-patient relationship. *Journal of Psychiatric and Mental Health Nursing, 12*(1), 64–74. http://dx.doi.org/10.1111/j.1365-2850.2004.00796.x.

Campbell, K., Clarke, K. A., Massey, D., & Lakeman, R. (2020). Borderline Personality Disorder: To diagnose or not to diagnose? That is the question. *International Journal of Mental Health Nursing*, *29*(5), 972-981.

Care Quality Commission. (2014). *National summary of the results for the 2014 community mental health survey.* Newcastle upon Tyne: Care Quality Commission.

Care Quality Commission. (2018). *The state of health care and adult social care in England 2017/18.* London: Care Quality Commisison.

Carr, S., Hafford-Letchfield, T., Faulkner, A., Megele, C., Gould, D., Khisa, C., Cohen, R., & Holley, J. (2019). "Keeping Control": A user-led exploratory study of mental health service user experiences of targeted violence and abuse in the context of adult safeguarding in England. *Health & Social Care in the Community*, *27*(5), e781-e792.

Casares, P., Johnstone, L. (2015). Integration of formulation in adult multidisciplinary services across a large NHS foundation trust – Phases 1 and 2: Training and integration. *Clinical Psychology Forum*, *275*, 20-27.

Castillo, H., & Ramon, S. (2017). “Work with me”: Service users’ perspectives on shared decision making in mental health. *Mental Health Review Journal, 22*(3), 166-178.

Castillo, H., Ramon, S., & Morant, N. (2013). A recovery journey for people with personality disorder. *International Journal of Social Psychiatry*, *59*(3), 264-273.

Charlesworth, G. (2010). Commentary. PSIGE newsletter, 112, 16-22.

Chieze, M., Hurst, S., Kaiser, S., & Sentissi, O. (2019). Effects of seclusion and restraint in adult psychiatry: A systematic review. *Frontiers in Psychiatry*, *10*, 491.

Clarke, I. (2015). The emotion focused formulation approach: Bridging individual and team formulation. *Clinical Psychology Forum*, *275*, 28–33. Retrieved from http://www.isabelclarke.org/clinical/icsthird.shtml

Clarke, V., & Demetriou, E. (2016). ‘Not a big deal’? exploring the accounts of adult children of lesbian, gay and trans parents. *Psychology & Sexuality*, *7*(2), 131-148.

Clarke, V., Hayfield, N., Ellis, S. J., & Terry, G. (2018). Lived experiences of childfree lesbians in the United Kingdom: A qualitative exploration. *Journal of Family Issues*, *39*(18), 4133-4155.

Clarke, I., & Nicholls, H. (2018). *Third wave CBT integration for individuals and teams: Comprehend, cope and connect*. Routledge.

Clarke, I. E., & Wilson, H. E. (2009). *Cognitive behaviour therapy for acute inpatient mental health units: Working with clients, staff and the milieu*. Routledge/Taylor & Francis Group.

Cleary, M. (2004). The realities of mental health nursing in acute inpatient environments. *International Journal of Mental Health Nursing*, *13*(1), 53-60.

Cleary, M., & Freeman, A. (2005). The cultural realities of clinical supervision in an acute inpatient mental health setting. *Issues in Mental Health Nursing*, *26*(5), 489-505.

Cleary, M., Hunt, G. E., Horsfall, J., & Deacon, M. (2012). Nurse-patient interaction in acute adult inpatient mental health units: A review and synthesis of qualitative studies. *Issues in Mental Health Nursing*, *33*(2), 66-79.

Coffey, M., Cohen, R., Faulkner, A., Hannigan, B., Simpson, A., & Barlow, S. (2016). Ordinary risks and accepted fictions: How contrasting and competing priorities work in risk assessment and mental health care planning. *Health Expectations, 20*(3)471-483.

Coffey, M., Hannigan, B., Barlow, S., Cartwright, M., Cohen, R., Faulkner, A., Jones, A., & Simpson, A. (2019). Recovery-focused mental health care planning and co-ordination

in acute inpatient mental health settings: A cross national comparative mixed methods study. *BMC Psychiatry*, *19*(1), 1-18.

Collins, B. (2018). Adoption and spread of innovation in the NHS. *London: The Kings Fund*.

Commons Treloar, A. J. (2009). Effectiveness of education programs in changing clinicians' attitudes toward treating borderline personality disorder. *Psychiatric Services*, *60*(8), 1128-1131.

Conyer, M. (2020). Reckoning: Reshaping clinical practice by grappling with privilege and colonisation. In *Beyond the Psychology Industry* (pp. 95-111). Springer, Cham.

Cooke, A., Smythe, W., & Anscombe, P. (2019). Conflict, compromise and collusion: dilemmas for psychosocially-oriented practitioners in the mental health system. *Psychosis*, *11*(3), 199-211.

Coulter, A. (1999). Paternalism or partnership? Patients have grown up—And there's no going back. *BMJ, 319*(719), 719-720.

Coulter, A., & Collins, A. (2011). Making shared decision-making a reality. *London: King's Fund*.

Craven-Staines, S., Dexter-Smith, S., & Li, K. (2010). Integrating psychological formulations into older people's Service-three years on (Part 3): Staff perceptions of formulation meetings. *PSIGE Newsletter*, *112*, 16-22.

Crawford, M. J., Rutter, D., Manley, C., Weaver, T., Bhui, K., Fulop, N., & Tyrer, P. (2002). Systematic review of involving patients in the planning and development of health care. *British Medical Journal*, *325*, 1-5.

Creswell, J. W. (2014). *A concise introduction to mixed methods research*. SAGE publications.

Creswell, J. W., Klassen, A. C., Plano Clark, V. L., & Smith, K. C. (2011). *Best practices for mixed methods research in the health sciences.* https://www.csun.edu/sites/default/files/best_prac_mixed_methods.pdf

Creswell, J. W., & Piano Clark, V. P. (2017). *Designing and conducting mixed methods research*. Sage publications.

Crocker, J. C., Boylan, A. M., Bostock, J., & Locock, L. (2017). Is it worth it? Patient and public views on the impact of their involvement in health research and its assessment: a UK-based qualitative interview study. *Health Expectations*, *20*(3), 519-528.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. Sage.

Cruickshank, J. (Ed.). (2003). *Critical realism: The difference it makes*. Routledge.

Currid, T. (2009). Experiences of stress among nurses in acute mental health settings. *Nursing Standard*, *23*(44), 40-46.

Cusack, P., Cusack, F. P., McAndrew, S., McKeown, M., & Duxbury, J. (2018). An integrative review exploring the physical and psychological harm inherent in using restraint in mental health inpatient settings. *International Journal of Mental Health Nursing*, *27*(3), 1162-1176.

Cutcliffe, J., & Happell, B. (2009). Psychiatry, mental health nurses, and invisible power: Exploring a perturbed relationship within contemporary mental health care. *International Journal of Mental Health Nursing*, *18*(2), 116-125.

Damsa, C., Adam, E., De Gregorio, F., Cailhol, L., Lejeune, J., Lazignac, C., & Allen, M. H. (2007). Intramuscular olanzapine in patients with borderline personality disorder: An observational study in an emergency room. *General Hospital Psychiatry*, *29*(1), 51–53. https://doi. org/10.1016/j.genhosppsych.2006.10.012

Danermark, B., Ekström, M., & Karlsson, J. C. (2019). *Explaining society: Critical realism in the social sciences*. Routledge.

Dattilio, F. M., Edwards, D. J., & Fishman, D. B. (2010). Case studies within a mixed methods paradigm: Toward a resolution of the alienation between researcher and practitioner in psychotherapy research. *Psychotherapy: Theory, Research, Practice, Training*, *47*(4), 427.

Davies, R. (2016). *What is going on in public involvement in health research? A qualitative exploration of aims, processes and outcomes* [Doctoral dissertation, University of the West of England]. University of the West of England Repository.

Davies, J., Sampson, M., Beesley, F., Smith, D., & Baldwin, V. (2014). An evaluation of Knowledge and Understanding Framework personality disorder awareness training: Can a co-production model be effective in a local NHS mental health Trust? *Personality and Mental Health*, *8*(2), 161-168.

Davis, A. (1996). Risk work and mental health. *Good practice in risk assessment and risk management*, *1*, 109-120.

Delaney, K. R., & Johnson, M. E. (2014). Metasynthesis of research on the role of psychiatric inpatient nurses: What is important to staff? *Journal of the American Psychiatric Nurses Association*, *20*(2), 125-137.

Denzin, N. K., & Lincoln, Y. S. (2005). *The Sage handbook of qualitative research*. Sage Publications Ltd.

Department of Health. (1999). *National service framework for mental health. Modern standards and service models*. Department of Health.

Department of Health (2004) *The Ten Essential Shared Capabilities: A Framework for the Whole of the Mental Health Workforce*. London: Department of Health.

Department of Health. (2015). Mental Health Act 1983: Code of practice. Norwich, UK. The Stationery Office.

De Ruysscher, C., Tomlinson, P., Vanheule, S., & Vandevelde, S. (2019). Questioning the professionalization of recovery: A collaborative exploration of a recovery process. *Disability & Society*, *34*(5), 797-818.

De Ruysscher, C., Vandevelde, S., Tomlinson, P., & Vanheule, S. (2020). A qualitative exploration of service users' and staff members' perspectives on the roles of inpatient settings in mental health recovery. *International Journal of Mental Health Systems*, *14*(1), 1-13.

DeViva, J. C. (2006). The effects of full-day and half-day workshops for health care providers in techniques for increasing resistant clients' motivation. *Professional Psychology: Research and Practice*, *37*(1), 83.

DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical education*, *40*(4), 314-321.

Dickens, G. L., Lamont, E., & Gray, S. (2016). Mental health nurses' attitudes, behaviour, experience and knowledge regarding adults with a diagnosis of borderline personality disorder: Systematic, integrative literature review. *Journal of Clinical Nursing*, *25*(13-14), 1848-1875.

Dillon, J. (2015, December 2-4). The Psychological is Political. [Conference presentation]. DCP 2015 Annual Conference, London, UK. https://www.youtube.com/watch?v=cQ4fSa18de8

Division of Clinical Psychology (DCP). (2001). *The core purpose and philosophy of the profession.* Leicester, England: British Psychological Society.

Division of Clinical Psychology. (2011). *Good practice guidelines on the use of psychological formulation*. Leicester, England: British Psychological Society.

Dixon, L. B., Krauss, N., Kernan, E., Lehman, A. F., & Deforge, B. R. (1995). Modifying the PACT model to serve homeless persons with severe mental illness. *Psychiatric Services*, 46(7) 684-88

Donald, F., Duff, C., Lawrence, K., Broadbear, J., & Rao, S. (2017). Clinician perspectives on recovery and borderline personality disorder. *The Journal of Mental Health Training, Education and Practice*, *12*(3), 199-209.

D'Orio, B. M., Purselle, D., Stevens, D., & Garlow, S. J. (2004). Reduction of episodes of seclusion and restraint in a psychiatric emergency service. *Psychiatric Services*, *55*(5), 581-83.

Douglas, K. S., & Reeves, K. A. (2010). *Historical-Clinical-Risk Management-20 (HCR-20) Violence Risk Assessment Scheme: Rationale, application, and empirical overview*. In R. K. Otto & K. S. Douglas (Eds.), *International perspectives on forensic mental health. Handbook of violence risk assessment* (p. 147–185). Routledge/Taylor & Francis Group.

Drummond, C., & Simpson, A. (2017). 'Who's actually gonna read this?' An evaluation of staff experiences of the value of information contained in written care plans in supporting care in three different dementia care settings. *Journal of Psychiatric and Mental Health Nursing*, *24*(6), 377-86.

Dudley, R., & Kuyken, W. (2014). Case formulation in cognitive behavioural therapy. In L. Johnstone & R. Dallos (Eds.), *Formulation in psychology and psychotherapy: Making sense of people's problems*. (2nd ed., pp. 18-42) Routledge.

Duff, C., Kokanović, R., Flore, J., Thomas, S. D. M., Callard, F., & Blackman, L. (2020). Perspectives on person-centred care for borderline personality disorder: A critical research agenda. *Health Sociology Review*, *29*(1), 1-15.

Duncan, E., Best, C., & Hagen, S. (2010). Shared decision making interventions for people with mental health conditions. *Cochrane Database of Systematic Reviews*, (1) 1-43.

Duxbury, J. (2016). Implementing the Six Core Strategies (REsTRAIN YOURSELF): Working in partnership to minimise harm to patients and staff by reducing the use of physical restraint. *London: Health Foundation Report*.

Duxbury, J., Baker, J., Downe, S., Jones, F., Greenwood, P., Thygesen, H., McKeown, M., Price, O., Scholes, A., Thomson, R., & Whittington, R. (2019). Minimising the use of physical restraint in acute mental health services: The outcome of a restraint reduction programme ('REsTRAIN YOURSELF'). *International Journal of Nursing Studies*, *95*, 40-48.

Easton, G. (2010). Critical realism in case study research. *Industrial Marketing Management*, *39*(1), 118-28.

Edelman, N., & Barron, D. (2016). Evaluation of public involvement in research: Time for a major re-think? *Journal of Health Services Research & Policy*, *21*(3), 209-211.

Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of community psychology*, *33*(4), 461-477.

Esmail, L., Moore, E., & Rein, A. (2015). Evaluating patient and stakeholder engagement in research: Moving from theory to practice. *Journal of Comparative Effectiveness Research*, *4*(2), 133-145.

Evans, C. (2020). *Experiencing psychological formulation: a qualitative study of service user perspectives* (Doctoral dissertation, University of East Anglia).

Fairclough, N., Jessop, B., & Sayer, A. (2004). Critical realism and semiosis. In J. Joseph & J. M. Roberts (Eds.), *Realism, discourse and deconstruction* (pp. 23–42). Routledge.

Falklöf, I., & Haglund, L. (2010). Daily occupations and adaptation to daily life described by women suffering from borderline personality disorder. *Occupational Therapy in Mental Health*, *26*(4), 354-374.

Fallon, P. (2003). Travelling through the system: The lived experience of people with borderline personality disorder in contact with psychiatric services. *Journal of Psychiatric and Mental Health Nursing*, *10*(4), 393-401.

Faulkner, A. (2017). *Knowing our own minds: the role and value of experiential knowledge in mental health research* [Doctoral dissertation, City, University of London]. City, University of London Institutional Repository.

Faulkner, A. (2020, June 1). *Exploring Survivor Research and White Privilege* [webinar presentation]. Racism in Mental Health, virtual webinar. https://www.youtube.com/watch?v=pT_9_TtGKhI

Felton, A., Repper, J., & Avis, M. (2018). The construction of people with mental health problems as risk objects: Findings of a case study inquiry. *Journal of Psychiatric and Mental Health Nursing*, *25*(9-10), 558-568.

Felton, A., & Stickley, T. (2018). Rethinking risk: a narrative approach. *The Journal of Mental Health Training, Education and Practice, 13*(1), 54-62.

Felton, A., Wright, N., & Stacey, G. (2017). Therapeutic risk-taking: A justifiable choice. *BJPsych Advances*, *23*(2), 81-88.

Fenton, K., & Kidd, K. (2019). Reflective practice groups in a mental health inpatient setting. *Mental Health Practice*, *24*(2).

Fischer, C. T. (2006). *Qualitative research methods for psychologists: Case demonstrations.* Academic Press.

Flynn, D., Kells, M., & Joyce, M. (2021). Dialectical behaviour therapy: implementation of an evidence-based intervention for borderline personality disorder in public health systems. *Current Opinion in Psychology, 37*, 152-157.

Fonagy, P., & Allison, E. (2014). The role of mentalizing and epistemic trust in the therapeutic relationship. *Psychotherapy*, *51*(3), 372.

Forsetlund, L., Bjørndal, A., Rashidian, A., Jamtvedt, G., O'Brien, M. A., Wolf, F., Davis, D., Odgaard-Jensen, J., & Oxman, A. D. (2009). Continuing education meetings and workshops: Effects on professional practice and health care outcomes. *Cochrane database of systematic reviews*, (2) 1-87.

Forsyth, A. (2007) The effects of diagnosis and non-compliance attributions on therapeutic alliance processes in adult acute psychiatric settings. Jo*urnal of Psychiatric and Mental Health Nursing*, *14*(1), 33-40. DOI: 10.1111/j.1365-2850.2007.01036.x.

Foucault, M. (2019). *Power: The essential works of Michel Foucault 1954-1984*. Penguin UK.

Fox, J. C., Blank, M., Rovnyak, V. G., & Barnett, R. Y. (2001). Barriers to help seeking for mental disorders in a rural impoverished population. *Community Mental Health Journal*, *37*(5), 421-436.

Foye, U., Li, Y., Birken, M., Parle, K., & Simpson, A. (2020). Activities on acute mental health inpatient wards: A narrative synthesis of the service users' perspective. *Journal of Psychiatric and Mental Health Nursing*, *27*(4), 482-493.

Gabrielsson, S., Sävenstedt, S., & Olsson, M. (2016). Taking personal responsibility: Nurses' and assistant nurses' experiences of good nursing practice in psychiatric inpatient care. *International Journal of Mental Health Nursing*, *25*(5), 434-443.

Galloway, A., & Pistrang, N. (2019). "We're stronger if we work together": experiences of naturally occurring peer support in an inpatient setting. *Journal of Mental Health*, *28*(4), 419-426.

Giguère, A., Zomahoun, H. T. V., Carmichael, P. H., Uwizeye, C. B., Légaré, F., Grimshaw, J. M., Gagnon, M. P., Auguste, D. U., & Massougbodji, J. (2020). Printed educational materials: effects on professional practice and healthcare outcomes. *Cochrane Database of Systematic Reviews*, (8), 1-217.

Gilburt, H., Rose, D., & Slade, M. (2008). The importance of relationships in mental health care: A qualitative study of service users' experiences of psychiatric hospital admission in the UK. *BMC Health Services Research*, *8*(1), 1-12.

Gillard, S., Borschmann, R., Turner, K., Goodrich-Purnell, N., Lovell, K., & Chambers, M. (2010). 'What difference does it make?' Finding evidence of the impact of mental health service user researchers on research into the experiences of detained psychiatric patients. *Health Expectations*, *13*(2), 185-194.

Gillard, S., Turner, K., & Neffgen, M. (2015). Understanding recovery in the context of lived experience of personality disorders: A collaborative, qualitative research study. *BMC Psychiatry*, *15*(1), 1-13.

Goodwin, I., Holmes, G., Newnes, C., & Waltho, D. (1999). A qualitative analysis of the views of in-patient mental health service users. *Journal of Mental Health*, *8*(1), 43-54.

Gordon, J., Franklin, S., & Eltringham, S. A. (2018). Service user reflections on the impact of involvement in research. *Research Involvement and Engagement*, *4*(1), 11.

Gould, D. (2012). Service users' experiences of recovery under the 2008 Care Programme Approach. *London: Mental Health Foundation, NSUN*.

Grant, A. (2015). Demedicalising misery: Welcoming the human paradigm in mental health nurse education. *Nurse Education Today*, *35*(9), 50-53.

Gravel, K., Légaré, F., & Graham, I. D. (2006). Barriers and facilitators to implementing shared decision-making in clinical practice: A systematic review of health professionals' perceptions. *Implementation Science*, *1*(1), 1-12.

Gray, L. M., Wong-Wylie, G., Rempel, G. R., & Cook, K. (2020). Expanding qualitative research interviewing strategies: Zoom video communications. *The Qualitative Report*, *25*(5), 1292-1301.

Green, J., & Thorogood, N. (2018). *Qualitative methods for health research*. Sage.

Griffiths, A. (2019, January). Reflections on using the Power Threat Meaning Framework in peer-led systems. In *Clinical Psychology Forum* (Vol. 313, pp. 9-14).

Grundy, A. C., Bee, P., Meade, O., Callaghan, P., Beatty, S., Olleveant, N., & Lovell, K. (2016). Bringing meaning to user involvement in mental health care planning: a qualitative exploration of service user perspectives. *Journal of Psychiatric and Mental Health Nursing*, *23*(1), 12-21.

Guetterman, T. C., & Fetters, M. D. (2018). Two methodological approaches to the integration of mixed methods and case study designs: A systematic review. *American Behavioural Scientist*, *62*(7), 900-918.

Gunderson, J. G. (2009). *Borderline personality disorder: A clinical guide*. American Psychiatric Publishing, Inc.

Gyamfi, N., Bhullar, N., Islam, M. S., & Usher, K. (2020). Knowledge and attitudes of mental health professionals and students regarding recovery: A systematic review. *International Journal of Mental Health Nursing*, *29*(3), 322-347.

Hagan, T., & Smail, D. (1997). Power-mapping—I. Background and basic methodology. *Journal of Community & Applied Social Psychology*, *7*(4), 257-267.

Haigh, R. (2005). Charismatic ideas: coming or going? *Therapeutic Communities, 26* (4), 367-382.

Hallquist, M. N., & Pilkonis, P. A. (2012). Refining the phenotype of borderline personality disorder: Diagnostic criteria and beyond. *Personality Disorders: Theory, Research, and Treatment*, *3*(3), 228.

Hamann, J., & Heres, S. (2014). Adapting shared decision making for individuals with severe mental illness. *Psychiatric Services, 65*(12), 1483-1486.

Hammersley, M., & Traianou, A. (2012). *Ethics in qualitative research: Controversies and contexts*. Sage.

Harrell, M., & Bradley, M. (2009). *Data collection methods: Semi-structured interviews and focus groups*. National Defense Research Institute.

Harrington, A., 2019. *Mind fixers: Psychiatry's troubled search for the biology of mental illness*. WW Norton & Company.

Harrits, S. G. (2011). More than method? A discussion of paradigm differences within mixed methods research. *Journal of Mixed Methods Research*, *5*(2), 150-166.

Hathcoat, J. D., & Meixner, C. (2017). Pragmatism, factor analysis, and the conditional incompatibility thesis in mixed methods research. *Journal of Mixed Methods Research*, *11*(4), 433-449.

Hayfield, N., Terry, G., Clarke, V., & Ellis, S. (2019). “Never Say Never?” Heterosexual, bisexual, and lesbian women’s accounts of being childfree. *Psychology of Women Quarterly*, *43*(4), 526-538.

Hazelton, M., Rossiter, R., & Milner, J. (2006). Managing the ‘unmanageable’: Training staff in the use of dialectical behaviour therapy for borderline personality disorder. *Contemporary Nurse*, *21*(1), 120-130.

Hem, H. M., Heggen, K., & Ruyter, K. W. (2008). Creating trust in an acute psychiatric ward. *Nursing Ethics*, *15*(6), 777-788.

Henderson, K. (2014). The importance of the therapeutic relationship in improving the patient's experience in the in-patient setting. *International Journal of Mental Health Nursing*, *23*(1), 97-97.

Heneghan, C., Wright, J., & Watson, G. (2014). Clinical psychologists' experiences of reflective staff groups in inpatient psychiatric settings: A mixed methods study. *Clinical Psychology & Psychotherapy*, *21*(4), 324-340.

Hermens, M. L., van Splunteren, P. T., van den Bosch, A., & Verheul, R. (2011). Barriers to implementing the clinical guideline on borderline personality disorder in the Netherlands. *Psychiatric services*, *62*(11), 1381-1383.

Herschell, A. D., Kolko, D. J., Baumann, B. L., & Davis, A. C. (2010). The role of therapist training in the implementation of psychosocial treatments: A review and critique with recommendations. *Clinical psychology review*, *30*(4), 448-466.

Hewitt, J., & Coffey, M. (2005). Therapeutic working relationships with people with schizophrenia: Literature review. *Journal of Advanced Nursing*, *52*(5), 561-570.

Hietanen, O. M., & Punamäki, R. L. (2006). Attachment and early working alliance in adult psychiatric inpatients. *Journal of Mental Health*, *15*(4), 423-435.

Higgins, R., Hurst, K., & Wistow, G. (1999). Nursing acute psychiatric patients: A quantitative and qualitative study. *Journal of Advanced Nursing*, *29*(1), 52-63.

Hodgetts, A., Wright, J., & Gough, A. (2007). Clients with borderline personality disorder: Exploring their experiences of dialectical behaviour therapy. *Counselling and Psychotherapy Research*, *7*(3), 172-177.

Hopkins, J. E., Loeb, S. J., & Fick, D. M. (2009). Beyond satisfaction, what service users expect of inpatient mental health care: A literature review. *Journal of Psychiatric and Mental Health Nursing*, *16*(10), 927-937.

Ingham, B. (2012). Case formulations. In R. Raghavan (Ed.) *Anxiety and depression in people with intellectual disabilities: Intervention strategies*, pp.89–104 Hove: Pavilion Publishing.

INVOLVE. (2012). What is public involvement in research? Retrieved from http://www.invo.org.uk/find-out-more/what-is-public-involvement-in- research-2/

Iozzino, L., Ferrari, C., Large, M., Nielssen, O., & De Girolamo, G. (2015). Prevalence and risk factors of violence by psychiatric acute inpatients: A systematic review and meta-analysis. *PloS One*, *10*(6),1-18.

Iqbal, N., Rees, M., & Backer, C. (2014). Decision making, responsibility and accountability in community mental health teams. *Mental Health Practice*, *17*(7) 26-28.

Isobel, S., & Edwards, C. (2017). Using trauma informed care as a nursing model of care in an acute inpatient mental health unit: A practice development process. *International Journal of Mental Health Nursing*, *26*(1), 88-94.

Ivers, N., Jamtvedt, G., Flottorp, S., Young, J. M., Odgaard-Jensen, J., French, S. D., O'Brien, M. A., Johansen, M., & Oxman, A. D. (2012). Audit and feedback: effects on professional practice and healthcare outcomes. *Cochrane database of systematic reviews*, (6), 1-219.

Ivey, G. (2006). A method of teaching psychodynamic case formulation. *Psychotherapy: Theory, Research, Practice, Training*, *43*(3), 322.

Jenkins, R., & Elliott, P. (2004). Stressors, burnout and social support: Nurses in acute mental health settings. *Journal of Advanced Nursing*, *48*(6), 622-631.

Jennings, H., Slade, M., Bates, P., Munday, E., & Toney, R. (2018). Best practice framework for Patient and Public Involvement (PPI) in collaborative data analysis of qualitative mental health research: methodology development and refinement. *BMC Psychiatry*, *18*(1), 1-11.

Johnstone, L. (1997). Self-injury and the psychiatric response. *Feminism & Psychology*, *7*(3), 421-426.

Johnstone, L. (2014). Using formulation in teams. In L. Johnstone & R. Dallos (Eds.), *Formulation in psychology and psychotherapy: Making sense of people's problems*. (2nd ed., pp. 216-242) Routledge.

Johnstone, L. (2018a). Psychological formulation as an alternative to psychiatric diagnosis. *Journal of Humanistic Psychology*, *58*(1), 30-46.

Johnstone, L. (Guest). (2018b, March 5). Mad in America [Audio podcast]. https://www.madinamerica.com/2018/03/dr-lucy-johnstone-power-threat-meaning-framework/

Johnstone, L. (2020, August 14). *Moving Beyond Psychiatric Diagnosis: Lucy Johnstone, PsyD*. Psychiatric Times. https://www.psychiatrictimes.com/view/moving-beyond-psychiatric-diagnosis-lucy-johnstone-psyd

Johnstone, L., Boyle, M., Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D., & Read, J. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis*. Leicester, England: British Psychological Society. Retrieved from www.bps.org.uk/PTM-Main

Johnstone, L., & Dallos, R. (2014*). Formulation in Psychology: Making sense of people's problems.* Routledge.

Johnstone, L., & Whittaker, D. (2018). An alternative to diagnosis. [Blog post]. Retrieved from http://blogs.exeter.ac.uk/exploringdiagnosis/an-alternative-to-diagnosis/

Jones, L., & Annesley, P. (2019). "Part of being human": evaluating the 4Ps model to support inpatient staff teams in reflecting on interpersonal dynamics. *The Journal of Mental Health Training, Education and Practice, 14*(4) 232-241.

Jones, A., & Crossley, D. (2008). 'In the mind of another's shame and acute psychiatric inpatient care: an exploratory study. A report on phase one: service users. *Journal of Psychiatric and Mental Health Nursing*, *15*(9), 749-757.

Jones, A., Hannigan, B., Coffey, M., & Simpson, A. (2018). Traditions of research in community mental health care planning and care coordination: A systematic meta-narrative review of the literature. *PLoS ONE, 13*(6), 1-23.

Jones, E. S., Wright, K. M., & McKeown, M. (2021). An integrative review exploring the experiences of service users carrying a diagnosis of personality disorder and student mental health nurses and the time they share together. *Nurse Education Today*, 98.

Jordan, J. V. (2001). A relational-cultural model: Healing through mutual empathy. *Bulletin of the Menninger Clinic*, *65*(1: Special issue), 92-103.

Junghan, U. M., Leese, M., Priebe, S., & Slade, M. (2007). Staff and patient perspectives on unmet need and therapeutic alliance in community mental health services. *The British Journal of Psychiatry*, *191*(6), 543-547.

Just, D., Palmier-Claus, J. E., & Tai, S. (2021). Positive risk management: Staff perspectives in acute mental health inpatient settings. *Journal of Advanced Nursing*, *77*(4), 1899-1910.

Kadra-Scalzo, G., Garland, J., Miller, S., Chang, C-K., Fok, M., Hayes, R., Moran , P., Hitesh, S., Young, A., & Stewart, R. (2021). Comparing psychotropic medication prescribing in personality disorder between general mental health and psychological services: a retrospective cohort study. *BJPsych Open, 7*(2) 1-28.

Kale, K., & Dantu, K. (2015). Clinicians attitude towards patients with borderline personality. A survey summary. *RCPsych in Wales ENewsletter–Winter/Spring*.

Kantor, V., Knefel, M., & Lueger-Schuster, B. (2017). Perceived barriers and facilitators of mental health service utilization in adult trauma survivors: A systematic review. *Clinical Psychology Review*, *52*, 52-68.

Katsakou, C., Marougka, S., Barnicot, K., Savill, M., White, H., Lockwood, K., & Priebe, S. (2012). Recovery in borderline personality disorder (BPD): A qualitative study of service users' perspectives. *PloS One*, *7*(5), e36517.

Katsakou, C., Marougka, S., Garabette, J., Rost, F., Yeeles, K., & Priebe, S. (2011). Why do some voluntary patients feel coerced into hospitalisation? A mixed-methods study. *Psychiatry Research*, *187*(1-2), 275-282.

Kelly, E. L., Fenwick, K., Brekke, J. S., & Novaco, R. W. (2016). Well-being and safety among inpatient psychiatric staff: The impact of conflict, assault, and stress reactivity. *Administration and Policy in Mental Health and Mental Health Services Research*, *43*(5), 703-716.

Kendjelic, E. M., & Eells, T. D. (2007). Generic psychotherapy case formulation training improves formulation quality. *Psychotherapy: Theory, Research, Practice, Training*, *44*(1), 66.

Kent, A. (2011). *Directing dinnertime: Practices and resources used by parents and children to deliver and respond to directive actions* [Doctoral dissertation, Loughborough University]. Loughborough University Repository.

Kitzinger, J. (1995). Qualitative research: Introducing focus groups. *British Medical Journal*, *311*(7000), 299-302.

Kuipers, E., Yesufu-Udechuku, A., Taylor, C., & Kendall, T. (2014). Management of psychosis and schizophrenia in adults: Summary of updated NICE guidance. *BMJ*, *348*, 1-4.

Kuyken, W., Padesky, C., & Dudley, R. (2009). Collaborative Case Conceptualization New York. *Guilford Press. Leahy, RL (2003). Cognitive Therapy Techniques: A Practitioner's Guide. New York: Guilford Press. Leahy, RL and Tirch, DD (2008). Cognitive behavioural therapy for jealousy. International Journal of Cognitive Therapy*, *1*(1), 18-32.

Laker, C., Cella, M., Callard, F., & Wykes, T. (2019). Why is change a challenge in acute mental health wards? A cross-sectional investigation of the relationships between burnout, occupational status and nurses' perceptions of barriers to change. *International journal of mental health nursing*, *28*(1), 190-198.

Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, research, practice, training*, *38*(4), 357.

Lambert, S. D., & Loiselle, C. G. (2008). Combining individual interviews and focus groups to enhance data richness. *Journal of Advanced Nursing*, *62*(2), 228-237.

Landreville, P., & Guérette, A. (1998). Psychometric properties of a modified version of the Treatment Evaluation Inventory for assessing the acceptability of treatments for geriatric depression. *Canadian Journal on Aging/La Revue Canadienne du Vieillissement*, *17*(4), 414-424.

Larsson, M., Pettersson, C., Skoog, T., & Eriksson, C. (2016). Enabling relationship formation, development, and closure in a one-year female mentoring program at a non-governmental organization: A mixed-method study. *BMC Public Health*, *16*(1), 1-14.

Laugharne, R., Priebe, S., McCabe, R., Garland, N., & Clifford, D. (2012). Trust, choice and power in mental health care: Experiences of patients with psychosis. *International Journal of Social Psychiatry*, *58*(5), 496-504.

Leamy, M., Clarke, E., Le Boutillier, C., Bird, V., Janosik, M., Sabas, K., Riley, G., Williams, J., & Slade, M. (2014). Implementing a complex intervention to support personal recovery: a qualitative study nested within a cluster randomised controlled trial. *PLoS One*, *9*(5), e97091.

Le Boutillier, C., Chevalier, A., Lawrence, V., Leamy, M., Bird, V. J., Macpherson, R., Williams, J., & Slade, M. (2015). Staff understanding of recovery-orientated mental health practice: A systematic review and narrative synthesis. *Implementation Science*, *10*(1), 1-14.

Lelliott, P., & Quirk, A. (2004). What is life like on acute psychiatric wards? *Current Opinion in Psychiatry*, *17*(4), 297-301.

Leon, A. C., Davis, L. L., & Kraemer, H. C. (2011). The role and interpretation of pilot studies in clinical research. *Journal of Psychiatric Research*, *45*(5), 626-629.

Levenson, H. (1973). Multidimensional locus of control in psychiatric patients. *Journal of Consulting and Clinical Psychology*, *41*(3), 397.

Levenson, H., & Strupp, H. H. (1997). Cyclical maladaptive patterns: Case formulation in time-limited dynamic psychotherapy. In T. D. Eells (Ed.), *Handbook of Psychotherapy Case Formulation* (pp. 164-197). Guilford Press.

Lewis-Morton, R., Harding, S., Lloyd, A., Macleod, A., Burton, S., & James, L. (2017). Co-producing formulation within a secure setting: A co-authorship with a service user and the clinical team. *Mental Health and Social Inclusion, 21*(4).

Lilja, L., & Hellzén, O. (2008). Former patients' experience of psychiatric care: A qualitative investigation. *International Journal of Mental Health Nursing*, *17*(4), 279-286.

Lincoln, Y. S., & Guba, E. G. (2003). Ethics: The failure of positivist science. In Y. S. Lincoln & N. K. Denzin (Eds.), *Turning points in qualitative research: Tying knots in a handkerchief* (219-238). AltaMira.

Lindenmeyer, A., Hearnshaw, H., Sturt, J., Ormerod, R., & Aitchison, G. (2007). *Health Expectations, 10*(3), 268-277.

Linehan, M. M. (1993). *Skills training manual for treating borderline personality disorder*. The Guilford Press.

Linehan, M. M. (2018). *Cognitive-behavioural treatment of borderline personality disorder*. Guilford Publications.

Linehan, M. M., & Kehrer, C. A. (1993). Borderline personality disorder. In D. Barlow (Ed.), *Clinical handbook of psychological disorders* (pp. 396–441). New York: Guilford.

Lorien, L., Blunden, S., & Madsen, W. (2020). Implementation of recovery-oriented practice in hospital-based mental health services: A systematic review. *International Journal of Mental Health Nursing*, *29*(6), 1035-1048.

Luciano, M., Sampogna, G., Del Vecchio, V., Loos, S., Slade, M., Clarke, E., Nagy, M., Kovacs, A., Munk-Jørgensen, P., Krogsgaard Bording, M., Kawohl, W., Rössler, Puschner, & Fiorillo, A. (2019). When does shared decision making is adopted in psychiatric clinical practice? Results from a European multicentric study. *European Archives of Psychiatry and Clinical Neuroscience*, 270, 645-653.

Mack, M., & Nesbitt, H. M. (2016). Staff attitudes towards people with borderline personality disorder. *Mental Health Practice*, *19*(8), 31-35.

Mackenzie, N., & Knipe, S. (2006). Research dilemmas: Paradigms, methods and methodology. *Issues in Educational Research*, *16*(2), 193-205.

Maclean, K. *ACT at Work: Feasibility study of an acceptance based intervention to promote mental health well-being and work engagement in mental health service staff*. [DClinPsy Dissertation. University of Glasgow]. Electronic Theses Online Service (EThOS). https://ethos.bl.uk/OrderDetails.do?uin=uk.bl.ethos.586779

Macneil, C. A., Hasty, M. K., Conus, P., & Berk, M. (2012). Is diagnosis enough to guide interventions in mental health? Using case formulation in clinical practice. *BMC Medicine*, *10*(1), 1-3.

Mann, K., Gordon, J., & MacLeod, A. (2009). Reflection and reflective practice in health professions education: A systematic review. *Advances in Health Sciences Education*, *14*(4), 595-621.

Marchal, B., Van Belle, S., Van Olmen, J., Hoerée, T., & Kegels, G. (2012). Is realist evaluation keeping its promise? A review of published empirical studies in the field of health systems research. *Evaluation*, *18*(2), 192-212.

Marsh, P., & Kelly, L. (2018). Dignity of risk in the community: A review of and reflections on the literature. *Health, Risk & Society*, *20*(5-6), 297-311.

Marziali, E. A. (1984). Prediction of outcome of brief psychotherapy from therapist interpretive interventions. *Archives of General Psychiatry*, *41*(3), 301-304.

Maslach, C., Schaufeli, W., & Leiter, M. (2001). Job Burnout. *Annual Review of Psychology, 52*(1), 397-422.

Maslow, A. H. (1943). A theory of human motivation. *Psychological Review, 50(4)*, 370-96.

Maxwell, J. A. (1995). Diversity and methodology in a changing world. Pedagogía 30, 32–40.

Maxwell, J. A. (2011). Epistemological heuristics for qualitative research. In H. Soini, E. L. Kronqvist, & G. L. Huber (Eds.), *Epistemologies for qualitative research* (pp. 10-23). Center for Qualitative Psychology.

McAndrew, S., Chambers, M., Nolan, F., Thomas, B., & Watts, P. (2014). Measuring the evidence: Reviewing the literature of the measurement of therapeutic engagement in acute mental health inpatient wards. *International Journal of Mental Health Nursing*, *23*(3), 212-220.

McBeath, A., Bager-Charleson, S., & Abarbanel, A. (2019). Therapists and academic writing: "Once upon a time psychotherapy practitioners and researchers were the same people". *European Journal for Qualitative Research in Psychotherapy*, *19*(9), 103-116.

McEvoy, P., & Richards, D. (2006). A critical realist rationale for using a combination of quantitative and qualitative methods. *Journal of Research in Nursing*, *11*(1), 66-78.

McGrath, B., & Dowling, M. (2012). Exploring registered psychiatric nurses' responses towards service users with a diagnosis of borderline personality disorder. *Nursing Research and Practice*, *2012,* 1-10.

McKeown, M., Wright, K. M., & Mercer, D. (2017). Care planning: A neoliberal three card trick. *Journal of Psychiatric and Mental Health Nursing*, *24*(6), 451-460.

McTiernan, K., Jackman, L., Robinson, L., & Thomas, M. (2020). A Thematic Analysis of the Multidisciplinary Team Understanding of the 5P Team Formulation Model and Its Evaluation on a Psychosis Rehabilitation Unit. *Community Mental Health Journal*, *2020*, 1-10.

Mental Capacity Act (2005) HMSO, London.

Mental Health Units (Use of Force) Act (2018) Chap. 27. Available at: http://www.legislation.gov.uk/ukpga/ 2018/27/pdfs/ukpga_20180027_en.pdf (Accessed 27 March 2021).

Messer, S. B. (1991). The case formulation approach: Issues of reliability and validity. *American Psychologist, 46*(12), 1348–1350.

Millar, B. (1998). The dignity of risk and the right to failure: A lesson from patient-focused care. *Journal of Clinical Nursing, 7*(4), 295-296.

Miller, J. B. (1976). *Toward a new psychology of women.* Boston: Beacon Press.

MIND. (2013). *Mental health crisis care: Physical restraint in crisis: A report on physical restraint in hospital settings in England*. https://www.mind.org.uk/media-a/4378/physical_restraint_final_web_version.pdf

Mistral, W., Hall, A., & McKee, P. (2002). Using therapeutic community principles to improve the functioning of a high care psychiatric ward in the UK. *International Journal of Mental Health Nursing*, *11*(1), 10-17.

Mohtashemi, R., Stevens, J., Jackson, P. G., & Weatherhead, S. (2016). Psychiatrists' understanding and use of psychological formulation: A qualitative exploration. *BJPsych Bulletin*, *40*(4), 212-216.

Molin, J., Graneheim, U. H., & Lindgren, B. M. (2016). Quality of interactions influences everyday life in psychiatric inpatient care—patients' perspectives. *International Journal of Qualitative Studies on Health and Well-being*, *11*(1), 1-11.

Moreno-Poyato, A. R., Montesó-Curto, P., Delgado-Hito, P., Suárez-Pérez, R., Aceña-Domínguez, R., Carreras-Salvador, R., Leyva-Moral, Lluch-Canut, T., & Roldán-Merino, J. F. (2016). The therapeutic relationship in inpatient psychiatric care: A narrative review of the perspective of nurses and patients. *Archives of Psychiatric Nursing*, *30*(6), 782-787.

Morgan, D. L. (1996). Focus groups. *Annual Review of Sociology*, *22*(1), 129-152.

Morgan, S. (2004). Positive risk-taking: An idea whose time has come. *Health Care Risk Report, 10(*10), 18–19.

Morgan, G., & Smircich, L. (1980). The case for qualitative research. *Academy of Management Review*, *5*(4), 491-500.

Morris, C., Smith, I., & Alwin, N. (2014). Is contact with adult mental health services helpful for individuals with a diagnosable BPD? A study of service users views in the UK. *Journal of Mental Health*, *23*(5), 251-255.

Morse, J.M. (1991). Approaches to qualitative-quantitative methodological triangulation. *Nursing Research, 40*, 120–122.

Mulvale, G. M., Nguyen, T. D., Miatello, A. M., Embrett, M. G., Wakefield, P. A., & Randall, G. E. (2019). Lost in transition or translation? Care philosophies and transitions between child and youth and adult mental health services: A systematic review. *Journal of Mental Health*, *28*(4), 379-388.

Mumma, G. H. (2011). Validity issues in cognitive-behavioural case formulation. *European Journal of Psychological Assessment*, *27*(1), 29.

Mumma, G. H., & Fluck, J. (2016). How valid is your case formulation? Empirically testing your cognitive behavioural case formulation for tailored treatment. *Cognitive Behaviour Therapist*, *9,* 1-25.

Muskett, C. (2014). Trauma-informed care in inpatient mental health settings: A review of the literature. *International Journal of Mental Health Nursing*, *23*(1), 51-59.

Naldemirci, Ö., Wolf, A., Elam, M., Lydahl, D., Moore, L., & Britten, N. (2017). Deliberate and emergent strategies for implementing person-centred care: A qualitative interview study with researchers, professionals and patients. *BMC Health Services Research*, *17*(1), 1-10.

Newman, D., O'Reilly, P., Lee, S. H., & Kennedy, C. (2015). Mental health service users' experiences of mental health care: An integrative literature review. *Journal of Psychiatric and Mental Health Nursing*, *22*(3), 171-182.

Newton-Howes, G., & Mullen, R. (2011). Coercion in psychiatric care: Systematic review of correlates and themes. *Psychiatric Services*, *62*(5), 465-470.

Newhouse, R. P., & Spring, B. (2010). Interdisciplinary evidence-based practice: Moving from silos to synergy. *Nursing Outlook*, *58*(6), 309-317.

NHS Quality Improvement Scotland (NHS QIS). (2005). Clinical governance and risk management: Achieving safe, effective, patient-focused care and services. NHS Quality Improvement Scotland, Edinburgh.

NICE. (2007, October 24) *Behaviour Change: General Approaches*. *Public Health Guideline (PH6).* https://www.nice.org.uk/guidance/ph6/chapter/Introduction

NICE. (2009). *Borderline personality disorder: Treatment and management*. London: National Institute for Health and Clinical Excellence.

NICE. (2012). *Patient experience in adult NHS services: Improving the experience of care for people using adult NHS services.* NICE Guideline. https://www.nice.org.uk/guidance/cg138/resources/patient-experience-in-adult-nhs-services-improving-the-experience-of-care-for-people-using-adult-nhs-services-pdf-35109517087429

NICE (2014). Behaviour change: individual approaches. *National Institute for Health and Care Excellence*.

NICE. (2020). *Principles of care for people with a personality disorder.* http://pathways.nice.org.uk/pathways/personality-disorders

Nicholson, C. (2018). *Interactions involving people with severe intellectual disabilities* [Doctoral dissertation, Anglia Ruskin University]. Anglia Ruskin University Repository. http://arro.anglia.ac.uk/id/eprint/704252

Nolan, P., Dallender, J., Soares, J., Thomsen, S., & Arnetz, B. (1999). Violence in mental health care: The experiences of mental health nurses and psychiatrists. *Journal of Advanced Nursing*, *30*(4), 934-941.

Nugus, P., Greenfield, D., Travaglia, J., Westbrook, J., & Braithwaite, J. (2010). How and where clinicians exercise power: Interprofessional relations in health care. *Social Science & Medicine*, *71*(5), 898-909.

O'Connell, B., & Dowling, M. (2013). Community psychiatric nurses' experiences of caring for clients with borderline personality disorder. *Mental Health Practice*, *17*(4), 1-18.

O'Connor, S., & Glover, L. (2017). Hospital staff experiences of their relationships with adults who self-harm: A meta-synthesis. *Psychology and Psychotherapy: Theory, Research and Practice*, *90*(3), 480-501.

O'Connor, K., Neff, D. M., & Pitman, S. (2018). Burnout in mental health professionals: A systematic review and meta-analysis of prevalence and determinants. *European Psychiatry*, *53*, 74-99.

O'Donovan, A. (2007). Patient-centred care in acute psychiatric admission units: Reality or rhetoric? *Journal of Psychiatric and Mental Health Nursing*, *14*(6), 542-548.

Onyett, S. (2007). *New ways of working for applied psychologists in health and social care: Working psychologically in teams.* Leicester, England: British Psychological Society.

O'Reilly, M., Kiyimba, N., & Drewett, A. (2020). Mixing qualitative methods versus methodologies: A critical reflection on communication and power in inpatient care. *Counselling and Psychotherapy Research, 21*(1), 66-76.

Padesky, C. A., & Mooney, K. A. (2012). Strengths-based cognitive–behavioural therapy: A four-step model to build resilience. *Clinical Psychology and Psychotherapy*, *19*(4), 283-290.

Pan, T. Y., Bruschwein, H. M., & Ward, W. L. (2021). Interprofessional Education: Psychology Trainee Experiences and Perspectives on Team Skills. *Journal of Clinical Psychology in Medical Settings*, 1-9.

Parry-Jones, B., Grant, G., McGrath, M., Caldock, K., Ramcharan, P., & Robinson, C. A. (1998). Stress and job satisfaction among social workers, community nurses and community psychiatric nurses: Implications for the care management model. *Health and Social Care in the Community*, *6*(4), 271-285.

Pelto-Piri, V., Wallsten, T., Hylén, U., Nikban, I., & Kjellin, L. (2019). Feeling safe or unsafe in psychiatric inpatient care, a hospital-based qualitative interview study with inpatients in Sweden. *International Journal of Mental Health Systems*, *13*(1), 1-10.

Peplau, H. E. (1952). *Interpersonal relations in nursing*. G. P. Putnam & Sons.

Pereira, S., & Woollaston, K. (2007). Therapeutic engagement in acute psychiatric inpatient services. *Journal of Psychiatric Intensive Care*, *3*(1), 3.

Perestelo-Perez, L., Gonzalez-Lorenzo, M., Perez-Ramos, J., Rivero-Santana, A., & Serrano-Aguilar, P. (2011). Patient involvement and shared decision-making in mental health care. *Current Clinical Pharmacology*, *6*(2), 83-90.

Peters, D. H., Adam, T., Alonge, O., Agyepong, I. A., & Tran, N. (2013). Implementation research: what it is and how to do it. *BMJ*, *347*, 1-7.

Pilgrim, D. (2020). *Critical realism for psychologists*. Routledge.

Pisciotta, M., Denneson, L. M., Williams, H. B., Woods, S., Tuepker, A., & Dobscha, S. K. (2019). Providing mental health care in the context of online mental health notes: advice from patients and mental health clinicians. *Journal of Mental Health*, *28*(1), 64-70.

Plamping, D. (1998). Change and resistance to change in the NHS. *BMJ*, *317*, 69-71.

Plano Clark, V. L. (2005). Cross-disciplinary analysis of the use of mixed methods in physics education research, counseling psychology, and primary care. *ETD collection for University of Nebraska - Lincoln*. AAI3163998. https://digitalcommons.unl.edu/dissertations/AAI3163998

Priebe, S., Richardson, M., Cooney, M., Adedeji, O., & McCabe, R. (2011). Does the therapeutic relationship predict outcomes of psychiatric treatment in patients with psychosis? A systematic review. *Psychotherapy and Psychosomatics*, *80*(2), 70-77.

Proctor, E. K., Landsverk, J., Aarons, G., Chambers, D., Glisson, C., & Mittman, B. (2009). Implementation research in mental health services: An emerging science with conceptual, methodological, and training challenges. *Administration and Policy in Mental Health and Mental Health Services Research*, *36*(1), 24-34.

Quirk, A., Lelliott, P., & Seale, C. (2005). Risk management by patients on psychiatric wards in London: An ethnographic study. *Health, Risk & Society*, *7*(1), 85-91.

Randall-James J, Caldwell K (2015) Developing team-based formulation groups. *Clinical Psychology Forum*. 275, 4-7.

Ravitz, P., Wondimagegn, D., Pain, C., Araya, M., Alem, A., Baheretibeb, Y., Hanlon, C., Fekadu, A., Park, J., Fefergrad, M. & Leszcz, M. (2014). Psychotherapy knowledge translation and interpersonal psychotherapy: Using best-education practices to transform mental health care in Canada and Ethiopia. *American Journal of Psychotherapy*, *68*(4), 463-488.

Read, J., Fink, P., Rudegeair, T., Felitti, V., & Whitfield, C. (2008). Child maltreatment and psychosis: A return to a genuinely integrated bio-psycho-social model. *Clinical Schizophrenia & Related Psychoses*, *2*(3), 235-254.

Read, J., Harper, D., Tucker, I., & Kennedy, A. (2018). How do mental health services respond when child abuse or neglect become known? A literature review. *International Journal of Mental Health Nursing*, *27*(6), 1606-1617.

Reddington, G. (2017). The case for positive risk-taking to promote recovery. *Mental Health Practice*, *20*(7), 29-32.

Redhead, S., Johnstone, L., & Nightingale, J. (2015). Clients' experiences of formulation in cognitive behaviour therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, *88*(4), 453-467.

Reid, R., Escott, P., & Isobel, S. (2018). Collaboration as a process and an outcome: Consumer experiences of collaborating with nurses in care planning in an acute inpatient mental health unit. *International Journal of Mental Health Nursing*, *27*(4), 1204-1211.

Repper, J. (2000). Adjusting the focus of mental health nursing: Incorporating service users' experiences of recovery. *Journal of Mental Health, 9* (6), 575–587, 575-587.

Repper & Perkins (2003) *Social inclusion and recovery, a model for mental health practice*. Bailliere Tindall.

Richards, J., Holttum, S., & Springham, N. (2016). How do "mental health professionals" who are also or have been "mental health service users" construct their identities? *Sage Open*, *6*(1), 1-14.

Richmond, H. L. (2014). *The dissemination and implementation of the Back Skills Training Trial (BeST)* [Doctoral dissertation, University of Warwick]. Electronic Theses Online Service (EThOS). https://ethos.bl.uk/OrderDetails.do?uin=uk.bl.ethos.640981

Ridley, C. R., & Jeffrey, C. E. (2017). The conceptual framework of thematic mapping in case conceptualization. *Journal of Clinical Psychology*, *73*(4), 376-392.

Ridley, C. R., Jeffrey, C. E., & Roberson III, R. B. (2017). Case mis-conceptualization in psychological treatment: An enduring clinical problem. *Journal of Clinical Psychology*, *73*(4), 359-375.

Rizvi, S. L., & Sayrs, J. H. (2020). Assessment-driven case formulation and treatment planning in dialectical behavior therapy: Using principles to guide effective treatment. *Cognitive and Behavioural Practice*, *27*(1), 4-17.

Robertson, S. J. (2018). *What does the process of developing a personal narrative involve and how does it contribute to mental health recovery?* [Doctoral dissertation, University of Southampton]. University of Southampton Institutional Repository. https://eprints.soton.ac.uk/422269/

Robertson, S., Carpenter, D., Donovan-Hall, M., & Bartlett, R. (2020). Using lived experience to develop a personal narrative workshop programme in order to aid mental health recovery. *Journal of Mental Health*, *29*(4), 483-491.

Robertson, J. P., & Collinson, C. (2011). Positive risk taking: Whose risk is it? An exploration in community outreach teams in adult mental health and learning disability services. *Health, Risk & Society*, *13*(2), 147-164.

Rogers, B., & Dunne, E. (2011). 'They told me I had this personality disorder… All of a sudden I was wasting their time': Personality disorder and the inpatient experience. *Journal of Mental Health*, *20*(3), 226-233.

Rose, D. (2018). Participatory research: Real or imagined. *Social Psychiatry and Psychiatric Epidemiology*, *53*(8), 765-771.

Rose, D., Evans, J., Laker, C., & Wykes, T. (2015). Life in acute mental health settings: Experiences and perceptions of service users and nurses. *Epidemiology and Psychiatric Sciences*, *24*(1), 90-96.

Royal College of Psychiatrists. (2010). A competency-based curriculum for specialist core training in psychiatry.

Rudge, S., Feigenbaum, J. D., & Fonagy, P. (2020). Mechanisms of change in dialectical behaviour therapy and cognitive behaviour therapy for borderline personality disorder: A critical review of the literature. *Journal of Mental Health*, *29*(1), 92-102.

Rushton, K., Ardern, K., Hopkin, E., Welsh, C., Gellatly, J., Faija, C., Armitage, C. J., Lidbetter, N., Lovell, K., Bower, P., & Bee, P. (2020). 'I didn't know what to expect': Exploring patient perspectives to identify targets for change to improve telephone-delivered psychological interventions. *BMC Psychiatry*, *20*, 1-13.

Sainsbury Centre for Mental Health. (1998). Keys to engagement: Review of people with severe mental illness who are hard to engage with services. London: Author.

Sandelowski, M. (2011). "Casing" the research case study. *Research in Nursing & Health*, *34*(2), 153-159.

Sayer, A. (2010). *Method in social science: Revised 2nd edition*. Routledge.

Scheherazade. (2018). [Blog post]. Power threat meaning threat power power power! Retrieved from: https://www.nsun.org.uk/power-threat-meaning-threat-powerpowerpower

Schön, U. K. (2013). Recovery in involuntary psychiatric care: Is there a gender difference? *Journal of Mental Health*, *22*(5), 420-427.

Schwandt, T. A. (2003). Three epistemological stances for qualitative inquiry. In Denzin, N. K. & Y. S. Lincoln (Eds.). *The landscape of qualitative research, theories and issues.* (2nd edition). Sage Publications.

Scott, A., Doughty, C., & Kahi, H. (2011). 'Having those conversations': The politics of risk in peer support practice. *Health Sociology Review*, *20*(2), 187-201.

Sekhon, Cartwright, & Francis, 2018, Acceptability of healthcare interventions: An overview of reviews and development of a theoretical framework. *BMC Health Services Research*, *17*(1), 1-13.

Shanks, V., Williams, J., Leamy, M., Bird, V. J., Le Boutillier, C., & Slade, M. (2013). Measures of personal recovery: A systematic review. *Psychiatric Services*, *64*(10), 974-980.

Shaw, J., Higgins, C., & Quartey, C. (2017). The impact of collaborative case formulation with high risk offenders with personality disorder. *The Journal of Forensic Psychiatry & Psychology*, *28*(6), 777-789.

Sheldon, K. (2011). Service users: experiences of risk and risk management. In R. Whittington & C. Logan (Eds.), *Self-harm and violence: Towards best practice in managing risk in mental health services* (pp. 11-34). Chichester: Wiley-Blackwell.

Shepherd, G., Boardman, J., & Burns, M. (2010). *Implementing recovery*: *A methodology for organisation change.* Sainsbury Centre for Mental Health.

Shepherd, A., Sanders, C., Doyle, M., & Shaw, J. (2016). Personal recovery in personality disorder: Systematic review and meta-synthesis of qualitative methods studies. *International Journal of Social Psychiatry*, *62*(1), 41-50.

Shields, M. A., & Ward, M. (2001). Improving nurse retention in the National Health Service in England: The impact of job satisfaction on intentions to quit. *Journal of Health Economics*, *20*(5), 677-701.

SHIFT Recovery Community. (2020). Using the Power Threat Meaning Framework in a self-help group of people with experience of mental and emotional distress. *Journal of Constructivist Psychology*, 1-9.

Sim, J. (1998). Collecting and analysing qualitative data: Issues raised by the focus group. *Journal of Advanced Nursing*, *28*(2), 345-352.

Simmons, P., Hawley, C. J., Gale, T. M., & Sivakumaran, T. (2010). Service user, patient, client, user or survivor: Describing recipients of mental health services. *The Psychiatrist*, *34*(1), 20-23.

Simpson, A., Coffey, M., Hannigan, B., Barlow, S., Cohen, R. L., Jones, A., Thornton, A., Všetečková, J., Haddad, K., & Marlowe, K. (2017). Cross-national mixed methods comparative case study of recovery-focused mental health care planning and coordination in acute inpatient mental health settings (COCAPP-A). *Health Services and Delivery Research*, *5*(26), 1-223.

Simpson, A., Miller, C., & Bowers, L. (2003). Case management models and the care programme approach: How to make the CPA effective and credible. *Journal of Psychiatric and Mental Health Nursing*, *10*(4), 472-483.

Skills for Care and Children's Workforce Development Council. (2007). *Providing effective supervision*. London: Skills for Care.

Slade, M. (2009). *Personal recovery and mental illness: A guide for mental health professionals*. Cambridge University Press.

Slade, M. (2017). Implementing shared decision making in routine mental health care. *World Psychiatry*, *16*(2), 146-153.

Smith, T. E., Burgos, J., Dexter, V., Norcott, J., Pappas, S. V., Shuman, E., Appel, A., Harrison, M. E., Nossel, I. R., & Essock, S. M. (2010). Best practices: Best practices for improving engagement of clients in clinic care. *Psychiatric Services*, *61*(4), 343-345.

Smith, C., & Elger, T. (2014). Critical realism and interviewing subjects. In P. K. Edwards, J. O'Mahoney, & S. Vincent (Eds.), *Studying organizations using critical realism: A practical guide* (pp. 109–131). Oxford University Press.

Sommerseth, R., & Dysvik, E. (2008). Health professionals' experiences of person-centered collaboration in mental health care. *Patient Preference and Adherence*, *2*, 259-269.

Sørgaard, K. W., Ryan, P., Hill, R., & Dawson, I. (2007). Sources of stress and burnout in acute psychiatric care: Inpatient vs. community staff. *Social Psychiatry and Psychiatric Epidemiology*, *42*(10), 794-802.

Spandler, H. (Guest). (2021, February 24). *Mad in America* [Audio podcast]. https://www.madinamerica.com/2021/02/uncomfortable-truths-survivor-narratives-interview-helen-spandler/

Spandler, H., & McKeown, M. (2017). Exploring the case for truth and reconciliation in mental health services. *Mental Health Review Journal, 22*(2), 83-94.

Staley, K. (2015). 'Is it worth doing?' Measuring the impact of patient and public involvement in research. *Research Involvement and Engagement*, *1*(1), 6.

Staniszewska, S., Mockford, C., Chadburn, G., Fenton, S. J., Bhui, K., Larkin, M., Newton, E., Crepaz-Keay., Griffiths, F., & Weich, S. (2019). Experiences of in-patient mental health services: Systematic review. *The British Journal of Psychiatry*, *214*(6), 329-338.

Stapleton, A., & Wright, N. (2019). The experiences of people with borderline personality disorder admitted to acute psychiatric inpatient wards: A meta-synthesis. *Journal of Mental Health*, *28*(4), 443-457.

Stenhouse, R. C. (2013). 'Safe enough in here?': Patients' expectations and experiences of feeling safe in an acute psychiatric inpatient ward. *Journal of Clinical Nursing*, *22*(21-22), 3109-3119.

Stickley, T. (2006). Should service user involvement be consigned to history? A critical realist perspective. *Journal of Psychiatric and Mental Health Nursing*, *13*(5), 570-577.

Stickley, T., & Felton, A. (2006). Promoting recovery through therapeutic risk taking. *Mental Health Practice*, *9*(8), 26-30.

Stroud, J. & Parsons, R. (2013). Working with borderline personality disorder: A small-scale qualitative investigation into community psychiatric nurses' constructs of borderline personality disorder. *Personal Mental Health* 7(3), 242–253. https://doi.org/10.1002/pmh.1214

Sturmey, P., McMurran, M., & Daffern, M. (2019). Case Formulation and Treatment Planning. In Polaschek, D. L. L., Day, A., Hollin, C. R. (Eds.), *The Wiley International Handbook of Correctional Psychology* (pp. 476-487). John Wiley & Sons, Incorporated.

Sullivan, L., (2018). Demedicalising crisis resolution home treatment teams: A psychological intervention for acute care services. *Clinical Psychology Forum*, *310*, 39-43.

Summers, A. (2006). Psychological formulations in psychiatric care: Staff views on their impact. *Psychiatric Bulletin*, *30*(9), 341-343.

Swales, M. A. (2009). Dialectical Behaviour Therapy: Description, research and future directions. *International Journal of Behavioural Consultation and Therapy*, *5*(2), 164-177.

Sweeney, A., Clement, S., Filson, B., & Kennedy, A. (2016). Trauma-informed mental healthcare in the UK: What is it and how can we further its development? *Mental Health Review Journal, 21*(3), 174-192.

Sweeney, A., Fahmy, S., Nolan, F., Morant, N., Fox, Z., Lloyd-Evans, B., Osborn, D., Burgess, E., Gilburt, H., McCabe, R., & Johnson, S. (2015). A mixed-methods study exploring therapeutic relationships and their association with service user satisfaction in acute psychiatric wards and crisis residential alternatives. *Health Services and Delivery Research, 2*(22), 1-103.

Sweeney, A., & Taggart, D. (2018). (Mis)understanding trauma-informed approaches in mental health. *Journal of Mental Health, 27*(5), 383-387.

Tarran-Jones, A., Summers, S. J., Dexter-Smith, S., & Craven-Staines, S. (2019). Team psychological formulation to create a shared understanding of distress: A qualitative study in an older people's mental health inpatient setting. *Quality in Ageing and Older Adults, 20*(2), 67-79.

Tashakkori, A., Teddlie, C., & Teddlie, C. B. (1998). *Mixed methodology: Combining qualitative and quantitative approaches*. Sage.

Teddlie, C., & Tashakkori, A. (2003). Major issues and controversies in the use of mixed methods in the social and behvioural sciences. In J.W. Creswell, V. L. P. Clark, M. L.

Gutmann, & W. E. Hanson (Eds.) *Handbook of mixed methods in social & behavioural research* (pp. 3-50). SAGE.

Telford, R., Beverley, C. A., Cooper, C. L., & Boote, J. D. (2002). Consumer involvement in health research: Fact or fiction? *British Journal of Clinical Governance, 7*(2), 92-103.

Terry, G., Hayfield, N., Clarke, V., & Braun, V. (2017). Thematic analysis. In C. Willig & W. S. Rogers (Eds.), *The SAGE handbook of qualitative research in psychology* (pp. 17-37). SAGE.

The Core Skills Education and Training Framework for Mental Health (Skills for Health & HEE, 2017).

Thibaut, B., Dewa, L. H., Ramtale, S. C., D'Lima, D., Adam, S., Ashrafian, H., Darzi, A., & Archer, S. (2019). Patient safety in inpatient mental health settings: A systematic review. *BMJ Open*, *9*(12), 1-19.

Thompson, L., & McCabe, R. (2012). The effect of clinician-patient alliance and communication on treatment adherence in mental health care: A systematic review. *BMC Psychiatry*, *12*(1), 1-12.

Tickle, A., & Braham, L. (2012). Meaningful use of service user contributions to professional training courses: Whose formulation is it anyway? *The Journal of Mental Health Training, Education and Practice 7*(3), 133-142.

Tikly, L. (2015). What works, for whom, and in what circumstances? Towards a critical realist understanding of learning in international and comparative education. *International Journal of Educational Development*, *40*, 237-249.

Tingleff, E. B., Bradley, S. K., Gildberg, F. A., Munksgaard, G., & Hounsgaard, L. (2017). "Treat me with respect". A systematic review and thematic analysis of psychiatric patients' reported perceptions of the situations associated with the process of coercion. *Journal of Psychiatric and Mental Health Nursing*, *24*(9-10), 681-698.

Topor, A., & Denhov, A. (2012). Helping relationships and time: Inside the black box of the working alliance. *American Journal of Psychiatric Rehabilitation*, *15*(3), 239-254.

Totman, J., Hundt, G. L., Wearn, E., Paul, M., & Johnson, S. (2011). Factors affecting staff morale on inpatient mental health wards in England: A qualitative investigation. *BMC Psychiatry*, *11*(1), 1-10.

Trainor, L. R., & Bundon, A. (2020). Developing the craft: Reflexive accounts of doing reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, 1-22.

Tse, S., Tsoi, E. W., Hamilton, B., O'Hagan, M., Shepherd, G., Slade, M., Whitley, R., & Petrakis, M. (2016). Uses of strength-based interventions for people with serious

mental illness: A critical review. *International Journal of Social Psychiatry*, *62*(3), 281-291.

Tudor, A. M. (2014). *The effectiveness of a pilot group intervention based on a cognitive-behavioural approach for adolescents with conduct problems in a mainstream school* [Doctoral dissertation, Institute of Education, University of London Electronic Theses Online Service (EThOS). https://ethos.bl.uk/OrderDetails.do?uin=uk.bl.ethos.642853

Tyler, N., Wright, N., Panagiotti, M., Grundy, A., & Waring, J. (2020). What does safety in mental health care transitions mean for service users and other stakeholder groups? An open-ended questionnaire study. *Health Expectations,* 00, 1-10.

Upsdell, T. (2018). Case formulation: A practical guide for beginners. In N. J. Pelling & L. J. Burton (Eds.), *The elements of psychological case report writing in Australia* (pp. 18–28). Routledge/Taylor & Francis Group.

Ussher, J. M. (2013). Diagnosing difficult women and pathologising femininity: Gender bias in psychiatric nosology. *Feminism & Psychology*, *23*(1), 63-69.

Venkatasubramanian, G., & Keshavan, M. S. (2016). Biomarkers in psychiatry: A critique. *Annals of Neurosciences*, *23*(1), 3.

Wagner, A. W., Rizvi, S. L., & Harned, M. S. (2007). Applications of dialectical behaviour therapy to the treatment of complex trauma-related problems: When one case formulation does not fit all. *Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studies*, *20*(4), 391-400.

Waldemar, A. K., Arnfred, S. M., Petersen, L., & Korsbek, L. (2016). Recovery-oriented practice in mental health inpatient settings: A literature review. *Psychiatric Services*, *67*(6), 596-602.

Wallace, C. J., Lecomte, T., Wilde, J., & Liberman, R. P. (2001). CASIG: A consumer-centred assessment for planning individualized treatment and evaluating program outcomes. *Schizophrenia Research*, *50*(1-2), 105-119.

Walsh, J., & Boyle, J. (2009). Improving acute psychiatric hospital services according to inpatient experiences. A user-led piece of research as a means to empowerment. *Issues in Mental Health Nursing*, *30*(1), 31-38.

Walsh, S., Kaselionyte, J., Taylor, S. J., & Priebe, S. (2018). What might affect acceptability of online positive psychology interventions for depression: A qualitative study on patient expectations. *BMC Psychiatry*, *18*(1), 1-12.

Walton, J. B., Plano Clark, V. L., Foote, L. A., & Johnson, C. C. (2020). Navigating intersecting roads in a mixed methods case study: A dissertation journey. *Journal of Mixed Methods Research*, *14*(4), 436-455.

Wand, T., White, K., & Patching, J. (2010). Applying a realist(ic) framework to the evaluation of a new model of emergency department based mental health nursing practice. *Nursing Inquiry*, *17*(3), 231-239.

Warrender, D. (2015). Staff nurse perceptions of the impact of mentalization-based therapy skills training when working with borderline personality disorder in acute mental health: A qualitative study. *Journal of Psychiatric and Mental Health Nursing*, *22*(8), 623-633.

Waugh, A., Vaughan, C., & Andrews, T. (2010). The importance and benefits of sharing the formulation process within an assistant psychologists' supervision. *PSIGE Newsletter*, *112*, 75-8.

Webster, N., Doggett, L., & Gardner, S. (2020). If you want to change the world you have to start with yourself: The impact of staff reflective practice within the Offender Personality Disorder pathway. *Probation Journal*, *67*(3), 283-296.

White, J. (Guest). (2020, November 25). Mad in America: Rethinking Mental Health [Audio podcast]. Retrieved from https://www.madinamerica.com/2020/11/rethinking-suicide-prevention-interview-critical-suicide-studies-jennifer-white/

White, R., & Karim, B. (2005). Patients' views of the ward round: A survey. *Psychiatric Bulletin*, *29*(6), 207-209.

White, J., Marsh, I., Kral, M. J., & Morris, J. (2015). *Critical suicidology: Transforming suicide research and prevention for the 21st century*. University of British Columbia Press.

White, J., & Morris, J. (2019). Re-thinking ethics and politics in suicide prevention: Bringing narrative ideas into dialogue with critical suicide studies. *International Journal of Environmental Research and Public Health*, *16*(18), 3236.

Wilkinson, E. (2015). UK NHS staff: stressed, exhausted, burnt out. *The Lancet*, *385*, 841-842.

Wilson, C., Rouse, L., Rae, S., & Kar Ray, M. (2017). Is restraint a 'necessary evil' in mental health care? Mental health inpatients' and staff members' experience of physical restraint. *International Journal of Mental Health Nursing*, *26*(5), 500-512.

Wilson, C., Rouse, L., Rae, S., & Kar Ray, M. (2018). Mental health inpatients' and staff members' suggestions for reducing physical restraint: A qualitative study. *Journal of Psychiatric and Mental Health Nursing*, *25*(3), 188-200.

Wood, L., & Alsawy, S. (2016). Patient experiences of psychiatric inpatient care: A systematic review of qualitative evidence. *Journal of Psychiatric Intensive Care*, *12*(1), 35-43.

Wood, M., & Welch, C. (2010). Are 'qualitative' and 'quantitative' useful terms for describing research? *Methodological Innovations Online*, *5*(1), 56-71.

Woodward, S., Berry, K., & Bucci, S. (2017). A systematic review of factors associated with service user satisfaction with psychiatric inpatient services. *Journal of Psychiatric Research*, *92*, 81-93.

Woollaston, K., & Hixenbaugh, P. (2008). 'Destructive Whirlwind': Nurses' perceptions of patients diagnosed with borderline personality disorder. *Journal of Psychiatric and Mental Health Nursing*, *15*(9), 703-709.

Wyder, M., Bland, R., Blythe, A., Matarasso, B., & Crompton, D. (2015). Therapeutic relationships and involuntary treatment orders: Service users' interactions with health-care professionals on the ward. *International Journal of Mental Health Nursing*, *24*(2), 181-189.

Xiao, C. L., Gavrilidis, E., Lee, S., & Kulkarni, J. (2016). Do mental health clinicians elicit a history of previous trauma in female psychiatric inpatients? *Journal of Mental Health*, *25*(4), 359-365.

Yeandle, J., Fawkes, L., Beeby, R., Gordon, C., & Challis, E. (2015). A collaborative formulation framework for service users with personality disorders. *Mental Health Practice*, *18*(5), 25-28.

Yin, R. K. (2009). How to do better case studies. In L. Bickman & D. J. Rog (Eds.), *The SAGE handbook of applied social research methods* (2nd ed., pp. 254-282). SAGE Publications.

Yin, R. K. (2013). Validity and generalization in future case study evaluations. *Evaluation*, *19*(3), 321-332.

Zanarini, M. C., Gunderson, J. G., Marino, M. F., Schwartz, E. O., & Frankenburg, F. R. (1989). Childhood experiences of borderline patients. *Comprehensive Psychiatry*, *30*(1), 18-25.

Zinkler, M., Gaglia, A., Arokiadass, S. R., & Farhy, E. (2007). Dialectical behaviour treatment: Implementation and outcomes. *Psychiatric Bulletin*, *31*(7), 249-252.

Zisman-Ilani, Y., Lysaker, P. H., & Hasson-Ohayon, I. (2021). Shared risk taking: Shared decision making in serious mental illness. *Psychiatric Services*.

Appendix A

Narrative of Project Origins and Journey

The following section is intended to familiarise the reader with the history of this research project, which has involved a winding and occasionally looping journey, ultimately concluding with the preceding chapters. My intent is to contextualise the study and convey, as well as I can, the challenges of conducting applied research in an NHS setting as an 'outsider;' that is, as a non-mental health professional. I will detail three particular challenges that presented throughout the research and occasioned changes in the design, conduct, and timeline for the project: coproduction; NHS ethics; and ward recruitment.

The origins of Enhance are described in Chapter 1. At the suggestion of the Enhance steering committee and to support this work by supporting outcomes with an academically rigorous evidence base, in 2016 Enhance extended its research programme with the present research project, a studentship to investigate the impact of 'clinical formulation' on rates of restraint in an acute adult inpatient ward within the local NHS Trust. The research was to be an applied design, involving both staff and service users in a trial to investigate the impact of clinical formulation on outcomes including the use of restraint. Aims aside, the design of the research was flexible and left to myself, the successful studentship candidate alongside my supervisory team, my primary supervisor having been instrumental in the initial conceptualisation and organisation of the studentship. I was particularly supported in the early stages of the research by Enhance's founders. While they did not play a major part in shaping the research design, they were eager to introduce me to ward gatekeepers and ensure I was provided adequate access to participants. One executive made several introductions on my behalf and took an active interest in the progress of the research, offering assistance where he could.

The original design was to involve two phases, which are described below, followed by the research aims and questions.

Phase 1.

Phase 1 of the study involved a pilot formulation trial to explore its relationship between the rate of restraint on the ward as well as individual outcomes for both staff and service users. A training package and a formulation model were developed for the purpose of this research. Data collected included both figures anonymously extracted from the Trust's computerised incident-recording database called Datix; as well as the collection of self-

reported questionnaires relating to service-user recovery, wellbeing, and perception of treatment; and staff empathy, self-efficacy, and knowledge.

Phase 2.

The following phase of the study involved semi-structured interviews with staff and service users. These interviews included both staff and service users from the ward which participated in Phase 1.

Study Design

Formulation as a real-life and contextualised practice is an emerging area of research, and its impact on the use of restraint and other individual outcomes is not yet well understood. Examination of its active ingredients, its causal mechanisms in the form of multi-context research is required to understand its effects more clearly. The Medical Research Council Guidance (MRC) on developing complex intervention (Craig et al., 2008) provided direction to the vision of ultimately developing a complex intervention to explore formulation and its relationship to restraint.

This research represents a feasibility study of formulation and its impact on the use of restraint. The project entailed the development of a formulation model to build on an evidence base for the usefulness of formulation within the inpatient mental health environment. The results of this project will determine whether further in-depth studies are warranted.

Feasibility and piloting, as described by Craig and colleagues (2008) is often a neglected stage of complex intervention development. This can result in wasted resources, time, and a lack of meaningful results due to difficulties in recruitment, delivery method, or acceptability which would otherwise be addressed with sufficient piloting stages (Bower et al., 2007). In line with the MRC's recommendations surrounding feasibility research are to include both qualitative and quantitative methods to sufficiently explore barriers and response rates (Craig et al., 2008), as well as enablers and wider cultural attitudes.

The following research questions were identified:

1. Does a pilot psychological formulation program lead to a change in the use of restraint in an acute psychiatric ward?
2. Does the pilot psychological formulation program impact measures of service-user wellbeing, recovery, and perception of treatment?

3. Does the pilot psychological formulation program impact measures of service-provider knowledge, self-efficacy, and empathy?
4. What are the enablers and barriers to achieving meaningful psychological formulation?
5. What are service user perspectives on the use of psychological formulation and how does this relate to their experiences of treatment on an inpatient ward?
6. What are mental health practitioner perspectives on the training and use of psychological formulation and how does this relate to experience of care provision and team working?

Challenge 1

The first of my particular difficulties presented itself from the beginning of the research: coproduction and its representation in my own research. It was essential for this research to involve service users as well as practitioners at as many stages as possible, and to align with the ethos of coproduction, 'nothing about us without us.' At the time I began this studentship in January 2017, many of the concepts were new to me. I had not been exposed to formulation in any great detail; I knew very little about the NHS and its structure and even less about inpatient care; and I was rather intimidated by the professionals and academics I was to work alongside. In my research for the application, though, I had learned about the idea of coproduction, which was a new concept for me, but seemed obvious upon examination: why would you not include service users in research that may be used to impact them?

Thus, from the beginning of my studentship, I worked with local the User and Carer Research and Development Manager to access individuals who were interested in participating in the research from an advisory perspective and to assemble a SUAG for the project. The intention was to recruit the advisory group to assist with the participant-facing materials, (including Participant Information Sheets, consent forms), selection of questionnaires, interview schedules, analysis, and dissemination. Importantly, the SUAG was also to assist with the development of the formulation model. The hope was to recruit a diverse advisory group, particularly as the initial intent was to recruit members locally, which in the R&D manager's experience had been majority white and middle class.

The difficulty encountered was how challenging and time-consuming it was to recruit for the advisory group. Even with the R&D manager's contacts and her optimism that this project with its broad scope for input, there were very few interested candidates and for months, I relied on one-off contributions until the assembly of a fairly stable membership of two in November 2017, several months after I began the studentship.

Challenge 2

The second challenge I faced was the NHS ethics procedure. I was particularly intimidated by this process: the opacity of it, particularly, as very few individuals in my proximity had undergone the procedure and little research exists representing the perspective of those applying for NHS ethics approval. This is especially true for research from students' perspectives (Brindley et al., 2020), although researchers conducting low-risk research have indicated the process is burdensome to the extent that it stifles the will and passion for research in their fields (Jansari et al., 2015; Teijlingen et al., 2008). Those who had first-hand experience of ethics committees had very little good to say about them: they were seen as a necessary hoop to jump through; an often painful and laborious process that nevertheless must be endured in order for the research to proceed.

At the time I was preparing my application, few University resources to assist with the process existed. Being separate from the University's own ethics process and panels, the usual authorities were not able to assist with the difficulty of interpreting the language used on the IRAS website, the platform the NHS uses for ethics applications, or answer any other questions I was left with, unable to discern answers in the online FAQs and other digital assistance. I relied heavily on the Trust's R&D, who, accurately or not, I did not perceive as being 'on my side' but rather was acting in the exclusive interest of the Trust. Thus, I felt I had little support but my own supervisory team and SUAG. I also found that due to the online system and procedures changing throughout the process, I sometimes was not provided with accurate information, or was met with uncertainty from those in authority positions. For example, the advice from R&D was to list myself as the principal investigator but was told by the REC to amend this to my supervisor.

Surprisingly, it was not the ethics committee itself I had difficulty with: in fact, the experience of attending the panel and answering their questions neared enjoyable and I was granted approval. They had cogent constructive criticism for me but they also had favourable things to say about the research, particularly about the involvement of the SUAG. What

caused the most delay, stress, and pressure was the inefficiency and bureaucracy outside of the committee itself. The lengthy waiting times; the need to provide minor details; the lack of straightforward answers; and the inflexibility of the amendment process all caused considerable stress and complication.

Challenge 3

It was the amendment procedure in particular that caused the biggest inconvenience, and this was tied to my third major challenge: that of the difficulty to secure a research setting. I had begun the process of recruitment with a clinical psychologist who had begun her role around the same time as I had begun recruiting, Site Supervisor One (SS1). She had agreed to act as the site supervisor and assisted with the early stages of the formulation model development. However, once the ethics approval was granted and it was time to access a ward to implement the research, SS1 shared that she would soon be going on maternity leave, and that she would be unable to assist me with the implementation of the research. Before she left, SS1 did her best to liaise between myself and the acute adult inpatient wards in one of the few directly local inpatient ward that was identified as appropriate for this research (the standard lengths of stay within the remaining wards were deemed too short-term). I met with representatives from the recovery ward alongside SS1; however, although these representatives initially agreed to host the research, they did not respond to any of my subsequent attempts to proceed with the research.

As the Trust included another hub where further inpatient units met the research setting inclusion criteria (adult acute inpatient wards), on the advice of my supervisory group as well as the SUAG, I then decided to get in contact with a clinical psychologist based at the hub, Site Supervisor Two (SS2). At the time, this was seen as serving a need in addition to a necessary pursuit of available resources as this hub had been expressed as receiving fewer research opportunities, had not benefited in the same way from Enhance's interventions as the more directly local wards, and offered a more diverse population of stakeholders, which may afford a more complex and perhaps richer opportunity for analysis. SS2 expressed enthusiasm to assist and we coordinated a plan for data collection. Responsible for providing psychological services to more than one ward, she was able to secure initial agreement for me to conduct the research at a medium-term stay adult acute ward at the outside hub, which I will call 'Reedling' ward here in the interest of anonymity. However, before we were able to coordinate a meeting between myself and the ward manager, SS2 informed me the ward

manager had retired unexpectedly and provided no notice to other staff members or managerial staff. SS2 then approached another ward that met the inclusion criteria, but they were unable to support the research due to a lack of capacity; I was then advised to there was still hope that Reedling ward could participate if the newly appointed ward manager was interested in participating in the research. However, the timeline was still precarious as the best-case scenario was that the new ward manager was an internal candidate, in which case we would not need to wait for them to be inducted.

Fortunately, the best-case scenario played out: an internal candidate was hired and was interested in participating in the research. Very quickly, myself, SS2, and the ward manager met for me to explain the research and, upon determining she was interested, organised times for me to attend the ward to discuss the research with the wider team, hoping they would then attend the training sessions, which were organised via the ward manager and SS2. Given our meeting was short-notice, I was delighted the ward manager was happy to proceed with the research before the Christmas break, which felt both personally nerve-wracking as it gave me little time to prepare, and yet a lifeline for the project's survival.

We went ahead with it anyway, although not without a hitch: on the morning of the intended first training session, I was informed by the Research and Development manager that I required – yet another – letter of access and so negotiated with SS2 for her to deliver the training, only for no one to attend this session due to an administrative error.

The next attempts were more successful: I attended Reedling twice in December 2018 to carry out the staff training. The ward manager attended the first session and the number of attendees including her was 7; at short notice (the morning of the training) the SS2 was not available on this day; however, her time-share partner and clinical psychologist was also in attendance to assist with clinical queries. This session seemed to be well received and all attendees signed the informed consent forms and completed the baseline measures.

The second session was attended by 9 participants, including SS2. In the session, the clinical psychologist indicated she did not believe it appropriate to have participants complete the informed consent or baseline measures until after the session. I did not feel it my place to challenge this position and did not express my doubt about the advisability of this. The general attitude demonstrated by the participants in this session from the outset were negative. It was communicated to me that despite my description of the research in my introduction meeting that the research was voluntary, the ward manager had made attendance mandatory and many staff voiced their resentment of this imposition and of the mixed messages. A similar experience was reported by Leamy and colleagues (2014), whose

participants expressed resentment and anger regarding a perception of having been 'forced' to participate in the research. Several times in the session, the conversation veered to complaints about how unhappy staff were with the manner in which the ward was being run. One participant in particular was vocal and appeared to impact the attitudes of the other participants. At the end of the session, led by this participant, not one attendee signed the consent form or filled out the baseline measures. After the conclusion of the session and the attendees had departed, SS2 shared her discouragement regarding the lack of engagement. She transferred roles shortly after this conversation took place.

Given the disappointingly low numbers at the first two training sessions and there being remaining staff members who had not been able to attend the earlier sessions, I agreed with the ward manager to arrange a final training session for after the festive break in the new 2019 year, as well as collecting follow-up data.

By February 2019, I had made the decision to exit from Reedling ward due further difficulties to establish a plan or timeline and decided to approach the last remaining eligible ward in the Trust, the 'Poppy' ward (name changed to maintain participants' anonymity). This decision was largely made on the recommendation of my SUAG, who indicated the consultant psychiatrist on this ward would be helpful. The turnaround to approach the last remaining eligible ward in the Trust was rapid and necessitated an amended research protocol due to the new research context, its resources, and my own timeline, which will be described below.

Negotiation of Challenges

Following my frustrated efforts to engage Reedling, I began negotiating access with another ward that was much more receptive and prepared to participate in the research. This ward was the only remaining adult inpatient ward within the Trust I had not approached. It had initially been discounted as a host given the original focus of the research on restraint and the fact that this last remaining ward, a specialist ward for individuals with a diagnosis of personality disorder, Poppy. Poppy has just over 10 beds and has approximately 10 staff. Poppy offers a year-long treatment of two 6-month rounds of DBT. Note: some details, such as the exact number of beds, are not specified to preserve anonymity of the ward.

I first contacted the consultant psychiatrist on Poppy ward to ascertain their interest in participating in the research and it was to them I reported throughout the process as they agreed to act as Site Supervisor Three (SS3). The design of the research as well as the staff

training was adapted according to the consultant psychiatrist's view of what would be pragmatic and acceptable to ward staff, including their existing formulation skillset; the time possibly spared alongside regular operations; and how many staff could be spared on the ward to attend the training.

The most significant changes to the research protocol were:

1) The elimination of the individual formulation sessions between the service user and the clinical psychologist given the absence a clinical psychologist on Poppy ward during the time when this research took place. The individual sessions had been integral to the previous version to collaboratively implement the formulation model developed for the purpose of this research, the 'Personal Narrative Model' (PNM) and determine the impact of the PNM's direct application on service user outcomes. The new research design left only interviews with both staff and service users, staff training, and baseline and post-training measures for staff and service users. This also resulted in the rationale for having service users complete questionnaires as measuring the indirect impact of the Model given they would not be directly involved with the staff training or the Model's application.
2) Poppy ward does not, by general rule, use restraint. The shift in what was originally the main focus of the research (the examination of the PNM on restraint use) thus pivoted to one of experience of treatment and the impact of psychological formulation practices.

Less significant changes included:

1) The addition of a staff focus group following the staff training, moving the staff and service user interviews to the beginning of the study;
2) Shifting what was once a series of one-off 4-hour staff training sessions on the PNM to all staff until saturation, instead the training was adapted to four 90-minute sessions, each focusing on a distinct element of the Model, its background and rationale, and its potential application.
3) The timescale also needed to be narrowed from three follow-up at 30, 60, and 90 days to one follow-up 30 days following the baseline measures.
4) The number of measures was reduced and, where available, the short version of measures replaced their longer counterparts.

5) The training needed to be sensitive to the ward's embedded Dialectical Behaviour Therapy treatment programme.

The amended protocol was submitted for NHS ethics approval in early March 2019 and was accepted in late March 2019. Interview schedules were developed alongside SUAG recommendations in April and interviews were set up in May 2019. Following these, the training programme was adapted to the new setting and implemented in August 2019, with service user interviews taking place in September-October 2019.

The amendment of the research protocol necessitated a revised theoretical framework and an understanding of the therapeutic model to facilitate its implementation in everyday practices. This meant learning about Dialectical Behaviour Therapy to describe ways in which the formulation model developed align and can be used within this overarching theoretical framework. It also meant learning this new ward's ways of working both to determine the format and model of training. Given that the Model was not being directly implemented, the training was conceptualised as an opportunity to think collaboratively about ways the PNM could be implemented to best meet the needs of both staff and service users. I also collaborated with gatekeepers around finding the best times for the staff training and the length of the training.

Following the amendment of the research design and focus, I faced a large amount of uncertainty: although I had redesigned and made the new protocol fit the new setting, stakeholders were seemingly satisfied, and in any case the research needed to proceed given the limited amount of time I had remaining, I was not convinced of the relevance and importance of the newly scaled-back design. I could not seem to fit together the component parts in my head, to make sense of the meaning of the project with a macro view; I simply could not seem to let go of the initial focus of the study: restraint, and its new focus: experience of treatment. In comparison, it felt to me less urgent, a tepid substitute. However, it was during a Service User Advisory Meeting analysing the service user interviews that the realisation came to me – to us as a group – that indeed, while restraint is an important topic in its own right, that it truly was not central to the setting in that several components of the ward were operating positively and well enough that outcomes like the lack of use of restraint were truly by-products and that without the existing culture and systems operating as they were, that it would have been an ill-advisedly context-free approach to simply focus on that one outcome measure. The questionnaires I had selected, the themes developed from interviews and focus groups, all lent themselves to a wider examination of the components of why the

ward was an example of positive care as well as where the gaps were: where the PNM could add value and address the needs of stakeholders.

References

Bower, P., Wilson, S., & Mathers, N. (2007). How often do UK primary care trials face recruitment delays? *Family Practice*, *24*(6), 601-603.

Brindley, R., Nolte, L., & Nel, P. W. (2020). We were in one place, and the ethics committee in another: Experiences of going through the research ethics application process. *Clinical Ethics*, *15*(2), 94-103.

Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I., & Petticrew, M. (2008). Developing and evaluating complex interventions: The new Medical Research Council guidance. *BMJ*, *337*. doi: 10.1136/bmj.a1655

Jansari, A., Cocchini, G., Jenkinson, P., Bajo, A., & Ietswaart, M. (2015). NHS ethics: Shoe-bombers and why 'less needs to be more'. *Cortex*, 71, 409-411.

Leamy, M., Clarke, E., Le Boutillier, C., Bird, V., Janosik, M., Sabas, K., Riley, G., Williams, J., & Slade, M. (2014). Implementing a complex intervention to support personal recovery: A qualitative study nested within a cluster randomised controlled trial. *PLoS One*, *9*(5), e97091.

van Teijlingen, E. R., Douglas, F., & Torrance, N. (2008). Clinical governance and research ethics as barriers to UK low-risk population-based health research? *BMC Public Health*, *8*(1), 396.

Appendix B

PNM Quantitative Outcome Data

B.1 Introduction

This phase of the research took place throughout the staff training described in Chapter 7 but was removed from the substantive thesis due to insufficient participant numbers. This is a 'quant' (Creswell, 2017) contribution, as the following results serve to add context as well as better situate the results of the qualitative phases of the research (Chapters 5, 6, and 8). Staff and service users at Poppy ward, who had initially been recruited to participate in interviews to explore their experiences of treatment (see Chapters 5 and 6), were invited to participate in an evaluation of staff training on the Personal Narrative Model (PNM), a psychological formulation model developed for the purpose of this thesis. Here, I will explore whether the quantitative, questionnaire-based outcomes from staff and service users changed from baseline (T1; before the first staff training session) to Time 2 (T2; after the fourth and last staff training session).

The research question, omitted from the substantive thesis, was, "What is the impact of staff training on the PNM and does the pilot psychological formulation program impact staff and service user outcomes?"

B.2 Method

B.2.1 Rationale for Questionnaires and Study Design

This phase explores the quantitative impact of staff training on the PNM. The intent was to investigate service user and staff outcomes through questionnaires taken before and after the training, although the design of the training and nature of the research as exploratory and collaborative alongside staff members meant that implementation of the Model itself depended on staff views and uptake and therefore any impact was expected to be indirect.

B.2.2 Procedure

I printed copies of the informed consent forms, participant information sheets, the demographic questionnaire and outcome measures (see Section B.2.3), as well as a blank DBT formulation template and a printed vignette on which to base the formulation. I also handed out sign-in sheets each session.

Data collection occurred at the first training session and the last of the four sessions (for a description of the training sessions, see Chapter 7). All participants were reminded

their participation in the research was voluntary and gave their informed consent before responding to the questionnaires or formulation task. As different participants attended the first and fourth session (bar one participant), the informed consent procedure was repeated at the fourth session for those participants who were not present at the first session.

Questionnaire-based data (details below) were collected from staff and service users at the time of the first training session as well as 30 days later, at the time of the fourth training session. Measures were taken before the first training session began (baseline) and again at the end of the fourth training session (T2).

Issues with data collection during the first session were that the consultant psychiatrist and site supervisor was present and flagged that most of the other participants were unqualified staff members who would not be sufficiently familiar with the formulation process to participate in the baseline formulation task. Thus, this element of the data collection was omitted from the baseline measures and renders the later formulations completed by participants in the fourth training sessions somewhat irrelevant. The inflexibility and time-consuming nature of the NHS ethics approval process meant that despite the challenges of collecting meaningful quantitative data, it was not feasible to change the protocol once data collection began.

B.2.3 Measures

B.2.3.1 Mental Health Practitioner Questionnaires. Mental health practitioners completed questionnaires at two time-points (see Figure B1 below). Baseline questionnaires took approximately 40 minutes to complete; follow-up questionnaires took 20 minutes to complete.

Table B1

Summary of Staff Questionnaire Collection at T1 and T2

Measure	T1	T2
Knowledge	X	X
Empathy	X	X
Organisational readiness for change	X	
Formulation activity	X	X

At the time of the training, mental health practitioners also completed a demographic questionnaire. Staff were also given a formulation template to complete using a service user vignette at both time points, although only this was only completed by participants at the second time-point. These measures were repeated 30 days following baseline to observe the immediate effects of the training.

B.2.3.1.1 Knowledge. Knowledge of formulation was measured with a 3-item scale developed by myself based on Ravitz and colleagues' (2014) scale assessing continuing education of psychotherapies for applied mental health practitioners (Ravitz, 2014). Items are rated on a 5-point scale ranging from 0 (None) to 4 (Very Good).

B.2.3.1.2 Empathy. Empathy was assessed using the 16-item Empathic Knowledge subscale of the valid and reliable Barrett and Lennard Relationship Inventory (BLRI; Barrett-Lennard, 1986); elimination of superfluous subscales is not unheard of (Hara et al. 2017; Suzuki & Farber 2016; Watson et al. 2014). The scale presents a 6-point Likert scale with responses ranging from -3 (I strongly feel that is not true) to +3 (I strongly feel that it is true). The Barrett-Lennard relationship inventory has high convergent validity with the Working Alliance Inventory (Horvath & Greenberg 1989) and the empathy subscale is adequately reliable according to a recent study on therapist empathy by Hara and colleague (2017; Cronbach's alpha = 0.94).

B.2.3.1.3 Organisational Readiness for Change Questionnaire. At baseline, staff completed a one-off measure of organizational readiness for change to establish existing attitudes towards change which could affect the success of implementation. The measure selected, VOCALISE (Laker et al. 2014), is comprised of 18 items, and is rated on a 6-point Likert scale ranging from 'strongly agree' to 'strongly disagree.' VOCALISE (Laker et al. 2014) was developed for use with nursing staff employed within the inpatient mental health ward and demonstrates acceptable criterion validity, with subscale alphas ranging from 0.59 to 0.73. Reliability is acceptable with an overall Chronbach's alpha of 0.75.

B.2.3.1.4 Case Formulation Quality Checklist. To evaluate formulation skills, staff were invited to complete a formulation template using a service user vignette. The resulting formulations were then evaluated using the revised version (McMurran & Bruford, 2016) of McMurran, and colleagues' (2012) Case Formulation Quality Checklist (CFQC), a 10-item checklist that addresses action orientation, coherence, simplicity, and other key indicators of a formulation's quality. The CFQC has been found to have adequate reliability (Minoudis et al., 2013) and has been used to evaluate training in previous research (Brown et al., 2016).

B.2.3.2 Service User Questionnaires. *The following questionnaires were completed by service users at the same two time-points as staff. Baseline questionnaires took approximately 30 minutes to complete; follow-up questionnaires took approximately 25 minutes to complete.*

Table B2

Summary of Service User Questionnaire Collection at T1 and T2

Measure	T1	T2
Recovery	X	X
Perception of treatment	X	X

Service user demographics were also taken at baseline. Baseline measures were repeated 30 days following baseline to observe the immediate (indirect) effects of the staff training, mirroring the time-points for the mental health practitioners. Criteria for the selection of measures were that, (1) as far as possible, measures were developed collaboratively alongside service users; and (2) measures were brief and accessible, minimising the burden of participation on service users who elected to volunteer for the research.

B.2.3.1.1 Recovery. Recovery was assessed using the validated 15-item short version of the Questionnaire About the Process of Recovery (QPR; Neil et al., 2009), which was developed in collaboration with service-users. Each item is scored using a 5-point Likert scale ranging from 0 (disagree strongly) to 4 (agree strongly). It has demonstrated adequate reliability and validity (convergent validity was 0.73 and reliability was 0.74; Williams et al., 2015).

B.2.3.2 Experience of Treatment. Perception of treatment was assessed using Soininen and colleagues' (2013) Secluded and Restrained Patients' Perception of their Treatment (S/R-PPT). This scale was developed in collaboration with service-users and contains 11 items and has been shown to be reliable (alpha coefficient of .916) and valid (concurrent validity with the CSQ-8, the Client Satisfaction Questionnaire-8 Japanese version of 0.876; Noda et al., 2012). Items are rated on a VAS rating from 1-100 mm, with 0 mm indicating 'strongly agree' to 100 mm indicating 'strongly disagree.'

B.2.4 Participants

B.2.4.1 Access to the Ward. This research followed the false start of a larger scale project and thus necessitated a substantial ethics amendment to suit the context of the new study site. I worked alongside the ward's gatekeeper, (the consultant psychiatrist and site supervisor), to develop a feasible research design. The research protocol, including anticipated recruitment numbers, was amended according to projected capacity of the ward to participate. The consultant psychiatrist put me in touch with the ward administrator and ward manager to coordinate recruitment of the ward staff and service users. The subsequent recruitment took place through these channels.

B.2.4.2 Recruitment. Staff and service users from Poppy were invited to participate in this research, representing a small population from which to recruit the sample for this research. This decision was based on both time and the resources available to carry out this dissertation. Recruitment was therefore a convenience (pragmatic) sample. Consultation with gatekeepers resulted in agreement on the goal of eight to ten staff members to be recruited based on the number of staff members employed on the ward and the ability to support their absence during the training. Five to ten service-users were agreed on based on the number of service users in residence on the ward as well as their likely capacity to consent to participation.

Attrition due to time commitments, discharge, and other life events is anticipated to affect the sample size; however, given the applied nature of the setting, this could not be controlled for. However, staff were asked in the initial phase how the training can be tailored to suit their needs and were hoped to minimize the risk of drop-out due to training-related factors.

B.2.4.2.1 Staff. For this project, I attended two staff group meetings (one in March, 2019 and one in May, 2019). I had staff sign up to attend; however, due to difficulties scheduling given the ward environment and the nature of rota shifts, and other barriers endemic to applied research on an acute ward, not all who signed up attended.

I also provided the ward manager and administrator with details of the research to disseminate in April, 2019. I coordinated with ward manager to attend ward three separate days for the training in August for several-hour-long blocks of time. Rooms were booked via the ward administrator and the ward manager emailed or announced to the staff team to alert them of my being on the ward ahead of each session.

B.2.4.2.2 Service Users. Prior to recruitment, I attended a ward community meeting attended by all service users and staff to introduce myself to service users as well as explain the research and offer an opportunity to answer questions. I also coordinated with the ward manager to identify service users who were interested in participating in the research. The ward manager explained to all service users the nature of the research and those who were interested were invited to attend a meeting with the researcher where they filled out the relevant questionnaires and later participated in interviews.

Service user recruitment was coordinated alongside the ward manager. Through the ward manager, a time was established to attend the ward to collect baseline questionnaires with service users. Rooms were arranged by the ward administrator. This process was repeated for the collection of post-staff training questionnaires.

When I attended the ward to collect follow-up measures from the service users, I was informed by the ward manager that it had been difficult to motivate individuals to participate in the research due to recent high-risk events that put the service users off-balance. As an outsider, it was also more difficult to recruit service users to engage in the research with me.

Both data collection phases began with a review of the study procedure and pertinent elements of informed consent, such as confidentiality and the option to withdraw at any time.

B.2.4.3 Inclusion Criteria. The main requirement for participation in the research was that individuals were either staff whose remit involved direct contact with service users (both qualified and unqualified) or receiving treatment on the host ward. The ward manager and I agreed that only service users deemed to have capacity to consent to participating were approached.

B.2.5 Intervention

The intervention, staff training on the PNM, is described in detail in Chapter 7.

B.2.6 Research Governance and Ethics

Approval for this research was granted by the REC Committee North West – Liverpool East.

B.2.7 Analysis

The original plan for the statistical analysis was for inferential statistical analyses to be conducted on the questionnaire data and formulation skill assessments collected. Provided

the data collected were normally distributed, paired t-tests will be used to compare assessments at baseline and at follow-up. If the data are not normally distributed, an alternative non-parametric test will be used. Given the interest in different outcomes for service users and staff, results for the two groups will be analysed separately but using the same statistical tests.

As the number of attendees who attended both the baseline and final training when the follow-up measures were again taken, however (n=1), a repeated-measures t-test was not appropriate. As the numbers were low ($n < 10$), the decision was made not to analyse the data using inferential statistics, as some researchers believe this can result in biased conclusions (Eldridge et al., 2016). Instead, descriptive statistics were used, as they are considered more exploratory and less conclusive (Paterson, 2018).

B.2.7.1 Descriptive Statistics. A statistician was consulted relating to the optimal analysis of the data collected; descriptive statistics were confirmed as the optimal means by which to identify whether any change to the outcome scores were in the anticipated direction, and confidence intervals represent the main focus of this study. No formal statistical significance tests were conducted (Eldridge et al., 2016; Lancaster, 2015; Lancaster et al., 2004). Means, standard deviations (SD), change in mean scores (SD) and standardised mean difference (SMD) are presented. Interpretation of SMDs were made via Cohen's index (1988): 0.2 indicates a small effect, 0.5 a medium effect and 0.8 a large effect. Data were analysed using IBM SPSS Statistics Version 26 (Statistical Package for the Social Sciences, IBM Corporation, 2019) and Microsoft Excel.

B.3 Results

B.3.1 Demographics

B.3.1.1 Staff. Sample characteristics varied at baseline and the final training session, particularly for staff. This was an unintended and unexpected result of the staff rota, the demands for support in a busy ward environment, and the resources available to facilitate a more extensive training implementation programme. Sample characteristics at each phase for both service users and staff are presented.

At T1, data was collected from seven participants total. Demographics for one participant was missing. Four participants identified as female and two male. Participants comprised of one clinical nurse specialist, one consultant psychiatrist, two HCAs, one

recovery worker, and one peer support worker. The average age of participants was 36.17 ranging from 23 to 47. The average number of years of training was four (ranging from 0 to 15 years); and an average of 10.4 years of clinical work experience (ranging from 0 to 15 years). Time in current role averaged 4.33, ranging from .17 to 12 years and time working at Poppy averaged 2.20 years (ranging from .17 to 4.17 years).

At T2, data was collected from nine participants. Demographics from three participants are missing. Of those who provided demographic data, three identified as female and three as male. One clinical nurse specialist, one deputy ward manager, one trainee nursing associate, two nurses and one HCA took part. The average age was 35.5 (range of 25 to 47), and the average years of training was 5.60, ranging from 2 to 17 years. Clinical work experience averaged 5.44 (ranging from .25 to 12 years) and years in current role averaged 3.14 (ranging from .25 to 12 years). Time working at Poppy averaged 2.14 years with a range of .25 to 4 years.

B.3.1.2 Service Users. All service users at Poppy identify as female. Three participants took part in T1, including one service user with a diagnosis of BPD, one service user with a diagnosis of BPD and complex PTSD and one service user with a diagnosis of BPD and autism. Participants were ages 22, 25, and 24.

Three participants took part in T2. Two participants from T1 took part and the third, new participant did not provide demographic data.

B.3.2 Staff Outcomes

A summary of staff outcomes from baseline and post-training (T1 and T2) is provided in Table B3.

Table B3

Summary of T1 to T2 Changes

Outcome	Group	n	Mean	Mean change	g (95% CI)
VOCALISE	T1	7	64.8571429		
Knowledge	T1	5	5	1.8333	-0.511 (-2.449, 1.427)
	T2	6	6.8333		

BLRI	T1	5	8.6000	1.5667	-0.182 (-4.835, 4.471)
	T2	6	10.1667		
CFQC	T2	5	31.6		

Note. VOCALISE; Knowledge questionnaire; BLRI (Barrett-Lennard Relationship Inventory); CFQC (Case Formulation Quality Checklist); Standard deviation (SD).

B.3.2.1 Organisational Readiness for Change. Staff responded to the measure of organisational readiness for change, VOCALISE (Laker et al., 2014) at baseline only. This was a flaw of the research design as different staff members attended different training sessions and therefore, not all staff who participated in the training provided a response to this measure. Therefore, caution must be exercised in interpreting the mean score from the seven staff members who provided a response, which was 64.86. According to Laker, Cella, Callard, and Wykes (2019), scores higher than 63 indicate negative perceptions of change.

B.3.2.2 Knowledge of Formulation. Difference in staff mean scores on knowledge of formulation also increased, which was in the expected direction.

B.3.2.3 Empathy. The empathy score (BLRI; Barrett-Lennard, 1986) increased between baseline and T2. Of note, one staff member's BLRI score was significantly higher than the rest at T2 (score of 31 compared to next highest score of 9). This may have inflated the T2 mean and skewed the mean change score in a positive direction.

B.3.2.4 Formulation Quality. Due to a change to the data collection procedure at the time the remaining baseline measures were taken, the Case Formulation Quality Checklist (CFQC) was only assessed at T2. Unlike Brown et al., (2018) formulations were rated by the myself. I have not undergone extensive training in formulation evaluation and therefore, the 5 formulations produced by staff attendees were not compared to a 'gold standard' based on the vignettes provided. Unfortunately, as formulation quality was not assessed at baseline, a comparison cannot be performed.

B.3.3 Service user outcomes.

Outcome	Group	n	Mean	SD	g (95% CI)
QPR	T1	3	36.6667	6.50641	0.304 (-7.419, 8.027)
	T2	3	33	12.00	
SRPPT	T1	3	629.6667	76.22554	-0.059 (-155.171, 155.053)
	T2	3	644	263.34008	

Note. QPR (Questionnaire about the Process of Recovery); SR-PPT (Secluded/Restrained Patients' Perception of their Treatment); Standard deviation (SD).

B.3.2.2 Recovery. The mean recovery score decreased marginally between baseline and T2.

B.3.2.3Experience of treatment. The mean service user experience of treatment score increased marginally between baseline and T2.

B.4 Discussion

The operation of the ward, the design of the research, and the resources available to me posed barriers to the meaningful implementation of the PNM on Poppy ward. The very small number of different staff members attending each training session and subsequently responding to the outcome measures creates difficulties in interpreting what data I was able to collect. The limited attendance at the staff training also restricted the implications for the training for service user treatment, as in order for the PNM to be put into action, attendance at all training sessions would likely have been required. This had knock-on effects for the impact of the staff training on service users. The limited outcome data that was collected appears to reflect this.

In terms of service user outcomes, again although low sample size greatly reduces the ability to draw conclusions from the resulting measures, contextual information noted in my research diary may serve to explain one of the negative directions of outcomes (recovery). At the time I attended the ward at T2, the ward manager noted that a disruption in the ward milieu had made recruitment difficult; this may have also impacted on self-reported recovery.

Although limited conclusions can be made based on the qualitative results presented here, the direction of mean change in staff knowledge of formulation scores and empathy between baseline and T2 are encouraging, as is the T2 formulation quality score. Compared to Brown and colleagues' (2018) scores, the T2 mean formulation scores in this study were very high. This may be a product of my own inexperience in scoring, assigning inflated scores to participants' formulations. Another possible explanation is that staff participating in the present research are mental health practitioners on a ward that implements DBT and ensures most, if not all staff, are trained in its principles while the participants in Brown's (2016) study were probation officers and thus may have had limited exposure to formulation practices. Thus, baseline understanding of formulation principles may have been higher in the participants in this study. However, the impact of the training cannot be ruled out.

To contextualise staff outcome scores and explore their views of the PNM as well as how other research with a similar remit, timeline, and available resources to the present study could address the barriers I encountered with this phase of the research, a staff focus group was held. This is described in Chapter 8.

References

Barrett-Lennard, G. T. (1986). The relationship inventory now: Issues and advances in theory, method and use. In L. S. Greenbert & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 439-476). Guilford Press.

Brown, S., Beeley, C., Patel, G., & Völlm, B. (2018). Training probation officers in case formulation for personality disordered offenders. *Criminal Behaviour and Mental Health*, *28*(1), 50-60.

Creswell, J. W., & Creswell, J. D. (2017). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage Publications.

Eldridge, S. M., Chan, C. L., Campbell, M. J., Bond, C. M., Hopewell, S., Thabane, L., & Lancaster, G. A. (2016). CONSORT 2010 statement: Extension to randomised pilot and feasibility trials. *BMJ*, *355*, i5239.

Hara, K. M., Aviram, A., Constantino, M. J., Westra, H. A., & Antony, M. M. (2017). Therapist empathy, homework compliance, and outcome in cognitive behavioural therapy for generalized anxiety disorder: Partitioning within-and between-therapist effects. *Cognitive Behaviour Therapy*, *46*(5), 375-390.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, *38*(2), 139.

Laker, C., Callard, F., Flach, C., Williams, P., Sayer, J., & Wykes, T. (2014). The challenge of change in acute mental health services: Measuring staff perceptions of barriers to change and their relationship to job status and satisfaction using a new measure (VOCALISE). *Implementation Science*, *9*(1), 1-11.

Laker, C., Cella, M., Callard, F., & Wykes, T. (2019). Why is change a challenge in acute mental health wards? A cross-sectional investigation of the relationships between burnout, occupational status and nurses' perceptions of barriers to change. *International Journal of Mental Health Nursing*, *28*(1), 190-198.

Lancaster, G. A. (2015). Pilot and feasibility studies come of age!.

Lancaster, G. A., Dodd, S., & Williamson, P. R. (2004). Design and analysis of pilot studies: recommendations for good practice. *Journal of Evaluation in Clinical Practice*, *10*(2), 307-312.

McMurran, M., & Bruford, S. (2016). Case formulation quality checklist: a revision based upon clinicians' views. *Journal of Forensic Practice, 18*(1), 31-38.

McMurran, M., Logan, C., & Hart, S. (2012). Case formulation. Quality checklist. Institute of Mental Health: Nottingham.

Minoudis, P., Craissati, J., Shaw, J., McMurran, M., Freestone, M., Chuan, S. J., & Leonard, A. (2013). An evaluation of case formulation training and consultation with probation officers. *Criminal Behaviour and Mental Health*, *23*(4), 252-262.

Neil, S. T., Kilbride, M., Pitt, L., Nothard, S., Welford, M., Sellwood, W., & Morrison, A. P. (2009). The questionnaire about the process of recovery (QPR): A measurement tool developed in collaboration with service users. *Psychosis*, *1*(2), 145-155.

Noda, T., Sugiyama, N., Ito, H., Soininen, P., Putkonen, H., Sailas, E., & Joffe, G. (2012). Secluded/restrained patients' perceptions of their treatment: Validity and reliability of a new questionnaire. *Psychiatry and Clinical Neurosciences*, *66*(5), 397-404.

Paterson, C. (2018). *Psychological intervention for acute mental health inpatient care: A meta-analysis and feasibility study* [Doctoral dissertation, Edinburgh Napier University]. Electronic Theses Online Service (EThOS). https://ethos.bl.uk/OrderDetails.do?uin=uk.bl.ethos.754111

Ravitz, P., Wondimagegn, D., Pain, C., Araya, M., Alem, A., Baheretibeb, Y., ... & Leszcz, M. (2014). Psychotherapy knowledge translation and interpersonal psychotherapy:

Using best-education practices to transform mental health care in Canada and Ethiopia. *American Journal of Psychotherapy*, *68*(4), 463-488.

Soininen, P., Välimäki, M., Noda, T., Puukka, P., Korkeila, J., Joffe, G., & Putkonen, H. (2013). Secluded and restrained patients' perceptions of their treatment. *International Journal of Mental Health Nursing*, *22*(1), 47-55.

Suzuki, J. Y., & Farber, B. A. (2016). Toward greater specificity of the concept of positive regard. *Person-Centered & Experiential Psychotherapies*, *15*(4), 263-284.

Watson, J. C., Steckley, P. L., & McMullen, E. J. (2014). The role of empathy in promoting change. *Psychotherapy Research*, *24*(3), 286-298.

Whiteley, S. (2004). The evolution of the therapeutic community. *Psychiatric Quarterly*, *75*(3), 233-248.

Williams, J., Leamy, M., Pesola, F., Bird, V., Le Boutillier, C., & Slade, M. (2015). Psychometric evaluation of the Questionnaire about the Process of Recovery (QPR). *The British Journal of Psychiatry*, *207*(6), 551-555.

Appendix C

Ethics Approval Letters

Figure C1
HRA Original Approval Letter

NHS
Health Research Authority

North West - Liverpool East Research Ethics Committee
Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

15 June 2018

Miss Aneita Pringle
Department of Psychology SCI 528
Anglia Ruskin University Cambridge Campus
East Road
CB11PT

Dear Miss Pringle

Study title:	**A Mixed-Method Investigation of a Psychological Formulation Program for Reducing Use of Restrictive Intervention in a Mental Health Inpatient Setting**
REC reference:	**18/NW/0212**
Protocol number:	**N/A**
IRAS project ID:	**227356**

Thank you for your letter of 02/05/2018, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair and Committee Member [redacted]

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further

information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System, at www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be

registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

The Committee has not yet completed any site-specific assessment (SSA) for the non-NHS research site(s) taking part in this study. The favourable opinion does not therefore apply to any non-NHS site at present. We will write to you again as soon as an SSA application(s) has been reviewed. In the meantime no study procedures should be initiated at non-NHS sites.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of advertisement materials for research participants [Recruitment Poster]	1	01 March 2018
Covering letter on headed paper [Cover Letter Re: Response to REC]	1	02 May 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Anglia Ruskin Idemnity Clinical Trial]	1	15 July 2017
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Anglia Ruskin Idemnity Clinical Trial]	1	15 July 2017
Interview schedules or topic guides for participants [Interview Schedule Service User Treatment Ward]	1	01 March 2018
Interview schedules or topic guides for participants [Interview Schedule Service User Control Ward]	1	01 March 2018
Interview schedules or topic guides for participants [Interview Schedule Staff Treatment Ward]	1	01 March 2018
Interview schedules or topic guides for participants [Interview Schedule Staff Control Ward]	1	01 March 2018
IRAS Application Form [IRAS_Form_18052018]		18 May 2018
Non-validated questionnaire		
Non-validated questionnaire		
Non-validated questionnaire		
Other [Debriefing Sheet Service Users Treatment Ward]	1	02 May 2018
Other [Debriefing Sheet Service Users Control Ward]	1	02 May 2018
Other [Debriefing Sheet Staff Team Treatment Ward]	1	02 May 2018
Other [Debriefing Sheet Staff Team Control Ward]	1	02 May 2018

Participant consent form [Informed Consent Form Service User Treatment Ward]	2	02 May 2018
Participant consent form [Informed Consent Form Service User Control Ward]	2	02 May 2018
Participant consent form [Informed Consent Form Staff Treatment Ward]	2	02 May 2018
Participant consent form [Informed Consent Form Staff Control Ward]	2	02 May 2018
Participant consent form [Informed Consent Forms Service Users Control]	2	02 May 2018
Participant information sheet (PIS) [Participant Information Sheet Service Users Treatment Ward]	2	02 May 2018
Participant information sheet (PIS) [Participant Information Sheet Service Users Control Ward]	2	02 May 2018
Participant information sheet (PIS) [Participant Information Sheet Staff Treatment Ward]	2	02 May 2018
Participant information sheet (PIS) [Participant Information Sheet Staff Control Ward]	2	02 May 2018
Participant information sheet (PIS) [Participant Information Sheet Service User Control Ward]	2	02 May 2018
Referee's report or other scientific critique report [Peer Review Submission]	04	04 July 2017
Research protocol or project proposal [Research Protocol]	1	01 March 2018
Summary CV for Chief Investigator (CI) [Chief Investigator CV]	2	16 April 2018
Summary CV for student [Student Researcher CV]	1	01 March 2018
Summary CV for student	2	16 April 2018
Summary CV for supervisor (student research) [Academic Supervisor CV]	1	01 March 2018
Summary CV for supervisor (student research) [Academic Supervisor CV]	1	05 March 2018
Summary CV for supervisor (student research) [Academic Supervisor CV]	1	08 March 2018
Validated questionnaire		
Validated questionnaire		
Validated questionnaire		
Validated questionnaire		
Validated questionnaire		

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at
http://www.hra.nhs.uk/hra-training/

18/NW/0212	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely

[redacted]

On Behalf Of

[redacted]

Chair

Email:nrescommittee.northwest-liverpooleast@nhs.net

Enclosures: "After ethical review – guidance for researchers" *[SL-AR2]*

Figure C2
Substantial First Amendment Approval

Health Research Authority

North West - Liverpool East Research Ethics Committee

Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Please note: This is the favourable opinion of the REC only and does not allow the amendment to be implemented at NHS sites in England until the outcome of the HRA assessment has been confirmed.

06 August 2018

Miss Aneita Pringle
Department of Psychology SCI 528
Anglia Ruskin University Cambridge Campus
East Road
CB11PT

Dear Miss Pringle

Study title:	**A Mixed-Method Investigation of a Psychological Formulation Program for Reducing Use of Restrictive Intervention in a Mental Health Inpatient Setting**
REC reference:	**18/NW/0212**
Protocol number:	**N/A**
Amendment number:	**1**
Amendment date:	**27 June 2018**
IRAS project ID:	**227356**

- Change in Sponsor.

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

The Sub-Committee did not raise any ethical issues.

Figure C3
Substantial Second Amendment Approval

NHS
Health Research Authority

North West - Liverpool East Research Ethics Committee
Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Tel: 0207 104 8019

Please note: This is the favourable opinion of the REC only and does not allow the amendment to be implemented at NHS sites in England until the outcome of the HRA assessment has been confirmed.

16 April 2019

Miss Aneita Pringle
Department of Psychology SCI 528
Anglia Ruskin University Cambridge Campus
East Road
CB11PT

Dear Miss Pringle

Study title:	**A Mixed-Method Investigation of a Psychological Formulation Program for Reducing Use of Restrictive Intervention in a Mental Health Inpatient Setting**
REC reference:	**18/NW/0212**
Protocol number:	**N/A**
Amendment number:	**Substantial Amendment 2**
Amendment date:	**01 March 2019**
IRAS project ID:	**227356**

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

The Sub Committee found no ethical issues with this amendment.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Covering letter on headed paper		01 March 2019
Covering letter on headed paper [IRAS changes]		01 March 2019
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Clinical trials coverage]		16 July 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Employers liability]		02 July 2018
Interview schedules or topic guides for participants [Focus group - staff team - tracked]	1	01 March 2019
Interview schedules or topic guides for participants [service users - tracked]	2	01 March 2019
Interview schedules or topic guides for participants [staff team - tracked]	2	01 March 2019
Notice of Substantial Amendment (non-CTIMP)	Substantial Amendment 2	01 March 2019
Other [Case formulation quality checklist]	2	01 March 2019
Other [Debrifing Sheet service users - tracked]	2	02 March 2019
Other [Debrifing Sheet staff team - tracked]	2	01 March 2019
Other [Statement of Activities]	4.1	10 May 2016
Participant consent form [service users - tracked]	3	01 March 2019
Participant consent form [Staff team - tracked]	3	01 March 2019
Participant information sheet (PIS) [service users - tracked]	3	01 March 2019
Participant information sheet (PIS) [staff team - tracked]	3	01 March 2019
Research protocol or project proposal [tracked]	3	01 March 2019
Validated questionnaire [Vocalise]	2	01 March 2019
Validated questionnaire [Knowledge questionnaire]	2	01 March 2019
Validated questionnaire [Demographic questionnaire]	2	01 March 2019
Validated questionnaire [Empathic understanding subscale]	2	01 March 2019
Validated questionnaire [recovery process]	2	01 March 2019
Validated questionnaire [secluded and restrained patients]	2	01 March 2019

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improving-research/learning/

18/NW/0212:	**Please quote this number on all correspondence**

Yours sincerely

[redacted]

PP: [redacted]
Chair

E-mail: nrescommittee.northwest-liverpooleast@nhs.net

Enclosures: *List of names and professions of members who took part in the review*

Copy to: *Miss Aneita Pringle*

Figure C4
First Non-Substantial Amendment

Amendment Categorisation and Implementation Information

Dear Dr. Kaminskiy,

IRAS Project ID:	227356
Short Study Title:	Study of the use of Personal Narratives for Reducing Restraint v. 1
Date complete amendment submission received:	04.07.19
Amendment No./ Sponsor Ref:	
Amendment Date:	04 July 2019
Amendment Type:	Non-substantial
Outcome of HRA and HCRW Assessment	**This email also constitutes HRA and HCRW Approval for the amendment,** and you should not expect anything further.
Implementation date in NHS organisations in England and Wales	35 days from date amendment information together with this email, is supplied to participating organisations **(providing conditions are met)**
For NHS/HSC R&D Office information	
Amendment Category	**A**

Thank you for submitting an amendment to your project. We have now categorised your amendment and please find this, as well as other relevant information, in the table above.

What should I do next?

Please read the information in IRAS, which provides you with information on how and when you can implement your amendment at NHS/HSC sites in each nation, and what actions you should take now.

If you have participating NHS/HSC organisations in any other UK nations please note that **we will** forward the amendment submission to the relevant national coordinating function(s).

If not already provided, please email to us any regulatory approvals (where applicable) once available.

When can I implement this amendment?

You may implement this amendment in line with the information in IRAS. Please note that you may only implement changes described in the amendment notice.

Figure C5
Second Non-Substantial Amendment

Amendment Categorisation and Implementation Information

Dear Dr. Kaminskiy,

IRAS Project ID:	227356
Short Study Title:	Study of the use of Personal Narratives for Reducing Restraint v. 1
Date complete amendment submission received:	23 May 2019
Amendment No./ Sponsor Ref:	2nd non-substantial amendment; 2 previous substantial amendments
Amendment Date:	23 May 2019
Amendment Type:	Non-substantial
Outcome of HRA and HCRW Assessment	**This email also constitutes HRA and HCRW Approval for the amendment,** and you should not expect anything further.
Implementation date in NHS organisations in England and Wales	35 days from date amendment information together with this email, is supplied to participating organisations **(providing conditions are met)**
For NHS/HSC R&D Office information	
Amendment Category	**A**

Thank you for submitting an amendment to your project. We have now categorised your amendment and please find this, as well as other relevant information, in the table above.

What should I do next?

Please read the information in IRAS, which provides you with information on how and when you can implement your amendment at NHS/HSC sites in each nation, and what actions you should take now.

If you have participating NHS/HSC organisations in any other UK nations please note that **we will** forward the amendment submission to the relevant national coordinating function(s).

If not already provided, please email to us any regulatory approvals (where applicable) once available.

When can I implement this amendment?

You may implement this amendment in line with the information in IRAS. Please note that you may only implement changes described in the amendment notice.

Who should I contact if I have further questions about this amendment?

Figure C6
Anglia Ruskin University School Ethics Approval

Principal investigator:	Aneita Pringle
Project supervisor:	Emma Kaminskiy
Project title:	A Study Exploring the 'Personal Narrative Mode'
SREP code:	EHPGR-28
Approval date	27-5-2020

Application decision: **Approve with revisions** under the terms of Anglia Ruskin University's Research Ethics Policy (Dated 8 September 2016, Version 1.7). Approval by SREP is subject to ratification by the FREP.

Changes to be made: These changes should be discussed and approved by your supervisor (all documents must be updated online) but do not need to be communicated to SREP, all changes must be made before data collection can start:

All face to face testing has been suspended until further notice. Any participant testing must be completed online. Please discuss with your supervisor if you need to make any changes to the design of your study. If you would like to change design to be online, please send an amendment form to the chair	
GENERAL COMMENTS FOR THE APPLICANT	Recruitment of those who have used mental health services and may be considered vulnerable to a degree (it would be unclear whether some may still have mental health issues) – the plan is to recruit via personal contacts and via course leaders to target students. Great care should be taken as to avoid any semblance of coercion, as there may not be a symmetric relationship.
Specific Comments for applicant: **Application Form**	Will phase 2 participants be given a choice to participate in 121 rather than focus group?
Specific Comments for applicant: **PIS**	Context missing - provide a sentence or two about the model and what it is for generally – for people unfamiliar with this current information may not be sufficient. Also what to expect in the videos and some general sense of the questions would be useful – as it stands PNR could be about anything ('psychological tool' is not particularly informative) More info on the model would be useful.
Specific Comments for applicant: **Other Documentation**	Advert – provide more details, 'psychological tool' can be misleading if participants do not have sufficient background. Debrief should be shortened dramatically, bearing in mind its purpose in practice signposting should be much more prominent.

All documents (PIS, Consent form, Debrief) given to participants, must be printed onto Anglia Ruskin University headed paper.

Any advert must contain the following statement:
The study has received ethics approval by the School Research Ethics Panel (SREP) and ratified by the Faculty Research Ethics Panel under the terms of Anglia Ruskin University's Policy and Code of Practice for the Conduct of Research with Human Participants

If you make changes to any aspect of your approved research, it is important that you discuss this with your supervisor as they can advise you on whether you need any additional ethical approval.

Ethical approval is given for a period of 1 year for undergraduates/masters students. If your research will extend beyond this period, it is your responsibility to apply for an extension before your approval expires.

It is your responsibility to ensure that you comply with Anglia Ruskin University's Research Ethics Policy and the Code of Practice for Applying for Ethical Approval at Anglia Ruskin University available at www.anglia.ac.uk/researchethics including the following.

- The procedure for submitting substantial amendments to the committee, should there be any changes to your research. You cannot implement these amendments until you have received approval from SREP for them.
- The procedure for reporting accidents, adverse events and incidents.
- The General Data Protection Requirement and Data Protection Act (2018).
- Any other legislation relevant to your research. You must also ensure that you are aware of any emerging legislation relating to your research and make any changes to your study (which you will need to obtain ethical approval for) to comply with this.
- Obtaining any further ethical approval required from the organisation or country (if not carrying out research in the UK) where you will be carrying the research out. This includes other Higher Education Institutions if you intend to carry out any research involving their students, staff or premises. Please ensure that you send the FREP/DREP copies of this documentation if required, prior to starting your research.
- Any laws of the country where you are carrying the research and obtaining any other approvals or permissions that are required.
- Any professional codes of conduct relating to research or requirements from your funding body (please note that for externally funded research, where the funding has been obtained via Anglia Ruskin University, a Project Risk Assessment must have been carried out prior to starting the research).
- Completing a Risk Assessment (Health and Safety) if required and updating this annually or if any aspects of your study change which affect this.
- Notifying the SREP Secretary when your study has ended.

Please also note that your research may be subject to monitoring.

Should you have any queries, please do not hesitate to contact me. May I wish you the best of luck with your research.

Yours sincerely,

[redacted]

SREP Chair

Date 30.9.2019
V1.5

Figure C6
Anglia Ruskin University School Ethics Approval

PARTICIPANT CONSENT FORM

Title of the project: A Study Exploring the 'Personal Narrative Model'
Main investigator and contact details: Aneita Pringle; aneita.pringle@pgr.anglia.ac.uk
Members of the research team: Dr. Emma Kaminskiy (primary supervisor); Dr. Jonathan Totman; Dr. Tine Van Bortel; Dr. Mick Finlay

1. I agree to take part in the above research. I have read the Participant Information Sheet (08 July 2020, V1.2) for the study.
   I understand what my role will be in this research, and all my questions have been answered to my satisfaction.

2. I understand that I am free to withdraw from the research at any time, without giving a reason.

3. I am free to ask any questions at any time before, during, and after the study.

4. I understand what information will be collected from me for the study.

5. For the purposes of the Data Protection Act (2018), if this project requires me to produce personal data, I have read and understood how Anglia Ruskin University (or name of institution of based at another organisation) will process it.

6. I understand what will happen to the data collected from me for the research.

7. I have been told about any disadvantages or risks regarding me taking part.

9. I understand that quotes from me may be used in the dissemination of the research.

10. I understand that the interview or focus group will be recorded.

11. I have been informed how my data will be processed, how long it will be kept and when it will destroyed.

12. I have been provided with a copy of this form and the Participant Information Sheet (08 July 2020, V1.2).

13. I confirm I am 18 years of age or older, English-speaking and are either/or a mental health practitioner with experience of working therapeutically one-to-one with service users and/or an individual who has used mental health services.

If you wish to withdraw from the research within a week of participating, please email me at aneita.pringle@pgr.anglia.ac.uk stating the title of the research. You do not have to give a reason for why you would like to withdraw.

Please let me know whether or not you are happy for data that has been collected up to this point to still be used. Should you wish for any data to also be removed, you are completely free to ask, provided you notify me within the time stated above.

Appendix D

Participant Information Sheets and Consent Forms

Figure D1

Service User Participant Information Sheet

NHS [redacted]

Anglia Ruskin University

Researcher: Aneita Pringle; aneita.pringle@pgr.anglia.ac.uk
Supervisor: Dr. Emma Kaminskiy; emma.kaminskiy@anglia.ac.uk

PARTICIPANT INFORMATION SHEET

Title of Study: Study of the Use of Personal Narratives in an Acute Setting

You are invited to take part in my PhD research study. Please carefully read the following information so that you understand why I'm conducting this research and how you will be involved. Please discuss it with friends, carers, and/or relatives. If you decide not to participate, your care will not be affected and no one will think differently about you. Please ask any questions or say if something is not clear. You will have at least 72 hours to think about whether you want to participate.

What is the purpose of the study?
In this PhD research, I am interested in looking at whether staff training in a psychological programme, the 'personal narrative' approach is helpful to your recovery. In addition, I will be exploring your views on the prevention of coercion on this ward, including restraint and coercion. I am also interested in your experiences of working with staff on your recovery on the ward. I will be comparing your and staff outcomes before and after the staff training.

Why is it important?
I hope that the staff training will help future service users and staff to enhance their communication and relationships and promote collaborative ways of working, as well as improve your and staffs' experiences of living in or working on the ward.

What will I need to do?
If you decide to participate, you will complete two rounds of questionnaires at two time-points. The first round will be at baseline (T1) and 30 days later (T2).

T1 questionnaires involve a questionnaire measuring recovery and perception of treatment, as well as a demographic questionnaire. In total, these questionnaires will take 30 minutes to complete.

T2 questionnaires involve measures of recovery and perception of treatment and will take 25 minutes to complete.

All data and information relating to the study will be stored in line with [redacted] confidentiality policies and information security policies. Anonymised transcripts will only be seen by the two academic researchers, and members of a mental health service user advisory group (made up of service users with lived experience of inpatient services) who have inputted into the design of the study.

Are there times when confidentiality would be broken?
The only time that confidentiality would be broken, per [redacted] is if anything is disclosed which indicates a risk of harm to yourself or others. In this case, your clinician will be informed and this will be discussed with you at the time of interview.

What are the potential benefits and risks of taking part?
As thanks, you will receive a voucher worth £10 for participating at the end of your part in the study. I do not predict there will be direct benefits to you for participating in this study. However, it is possible for the staff team to gain a better understanding of you and your needs, which may improve their therapeutic relationship with you. I also hope that you will feel valued in participating and helping future service users and staff.

There is a risk that the interview will raise difficult and upsetting issues as you will be asked about your experiences of life in the ward. At any point, you may ask to move onto the next question, take a break, or end the interview without giving a reason. You are welcome to bring someone with you to the interview (e.g. a family member, friend, member of care team, or advocate) who can sit outside of the room or sit in the room with you throughout the interview (though they should not participate in the discussion). If any significant distress is experienced, you have the choice of either contacting your mental health care provider, your GP, or a relevant helpline/website:
Rethink Mental Health: 03005000927; www.rethink.org
SANE: 08457678000; www.sane.org.uk
Mind: 03001233393l; www.mind.org.uk
Samaritans: 08457909090; www.samaritans.org
[redacted]

What will happen at the end of the study?
A summary of the findings will be sent to you at the end of the study (if you consent to providing the researchers with a phone number, email address or home/work address for it to be sent to on the informed consent form). The results will also be written up as a paper with the aim of publication and will be presented to [redacted]

What if I have a problem or concern?
If you have any questions or concerns about any aspect of this study, you should ask to speak with myself, my supervisor, Emma Kaminskiy, or a member of your care team. Contact details are listed at the top and bottom of this form.

If you have a complaint about the research study and wish to speak to somebody independent of the study, you can do this by contacting the [redacted]

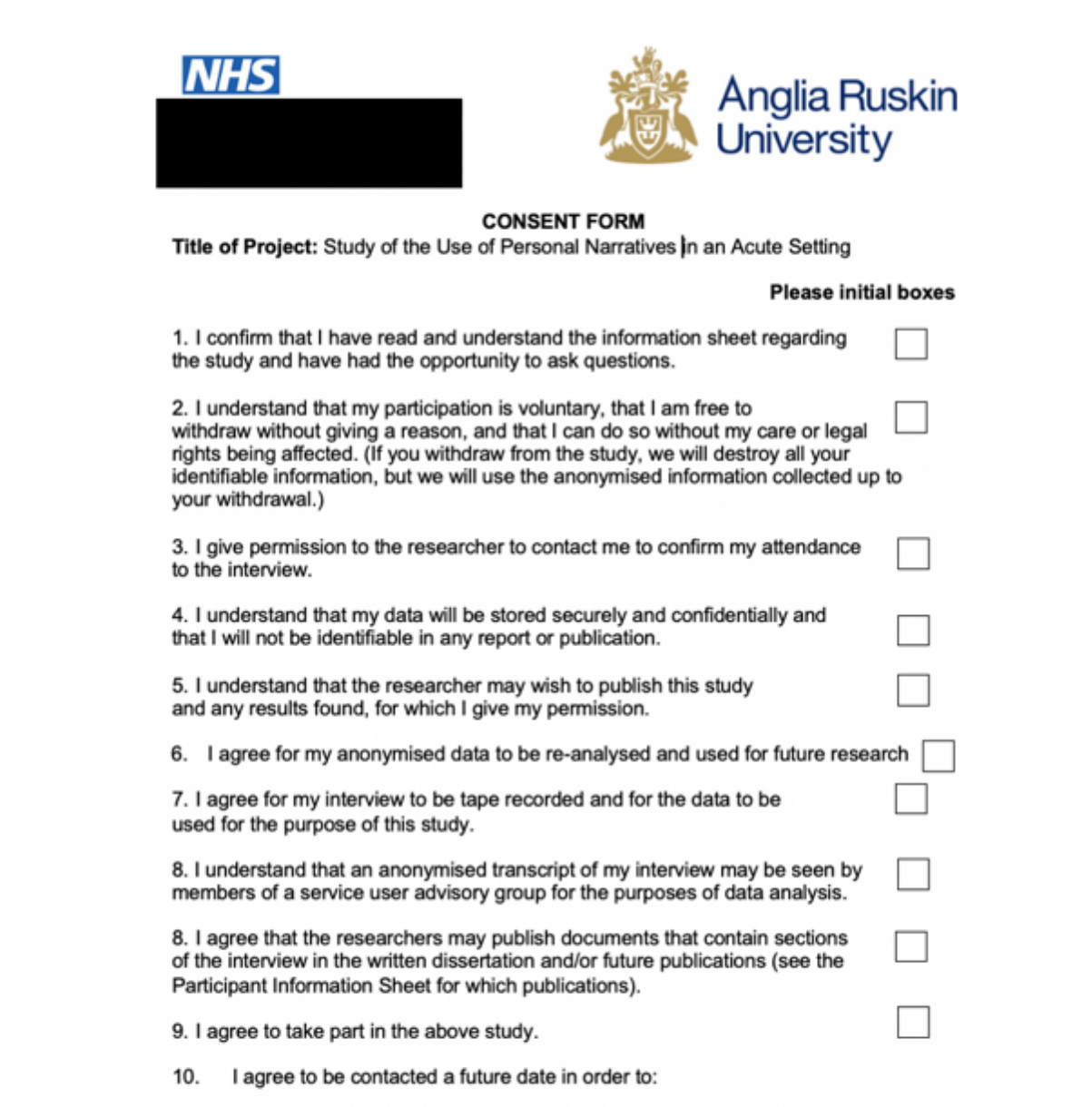
Who has reviewed the study?
This study has been reviewed and given a favourable opinion by North West - Liverpool East Research Ethics Committee (18/NW/0212).

Contact for further information
Please contact Aneita Pringle by email at aneita.pringle@pgr.anglia.ac.uk
Please contact Dr Emma Kaminskiy at emma.kaminskiy@anglia.ac.uk

Please keep a copy of this information so you can refer to it again if you wish.

Figure D2

Service User Consent Form



NHS [redacted]

Anglia Ruskin University

CONSENT FORM

Title of Project: Study of the Use of Personal Narratives in an Acute Setting

Please initial boxes

1. I confirm that I have read and understand the information sheet regarding the study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary, that I am free to withdraw without giving a reason, and that I can do so without my care or legal rights being affected. (If you withdraw from the study, we will destroy all your identifiable information, but we will use the anonymised information collected up to your withdrawal.) ☐

3. I give permission to the researcher to contact me to confirm my attendance to the interview. ☐

4. I understand that my data will be stored securely and confidentially and that I will not be identifiable in any report or publication. ☐

5. I understand that the researcher may wish to publish this study and any results found, for which I give my permission. ☐

6. I agree for my anonymised data to be re-analysed and used for future research ☐

7. I agree for my interview to be tape recorded and for the data to be used for the purpose of this study. ☐

8. I understand that an anonymised transcript of my interview may be seen by members of a service user advisory group for the purposes of data analysis. ☐

8. I agree that the researchers may publish documents that contain sections of the interview in the written dissertation and/or future publications (see the Participant Information Sheet for which publications). ☐

9. I agree to take part in the above study. ☐

10. I agree to be contacted a future date in order to:

1. Provide a summary of the findings at the end of the study. ☐
2. Send me a small thank-you gift for participating if I am unable to receive it in person. ☐

.....	.....	.....
Name	Date	Signature
.....	.....	.....
Name of person taking consent (if not researcher, state position)	Date	Signature
.....	.....	.....
Researcher	Date	Signature

.....	.....
Participant telephone number	Participant email address / home address / work address

Figure D3

Staff Participant Information Sheet

NHS [redacted]

Anglia Ruskin University

Researcher: Aneita Pringle; aneita.pringle@pgr.anglia.ac.uk
Supervisor: Dr. Emma Kaminskiy; emma.kaminskiy@anglia.ac.uk

PARTICIPANT INFORMATION SHEET

Title of Study: Study of the Use of Personal Narratives in an Acute Setting

Thank you for participating in this study!

You are being invited to take part in my PhD research study. Please take time to read the following information carefully so you can understand why the research is taking place and what it will involve. If you decide not to participate, I will not feel or think differently about you. Please ask any questions or say if something is not clear. You will have at least 72 hours to think about whether you want to participate.

What is the purpose of the study?
In this PhD research, I am interested in looking at whether staff training in a model of formulation developed for the purpose of this research, the 'personal narrative' approach, is helpful in promoting formulation skills. I am particularly interested in whether formulation skills improve service-users' perception of treatment, including their experiences of restraint and seclusion by indirectly enhancing relationships between staff and service users. I am also interested in other outcomes for both service users and the staff team. To address my interests, I am comparing staff formulation skills as well as staff and service-user outcomes before and after the staff formulation training.

Why is it important?
I hope that this personal narrative approach will help future staff with formulation skills and ultimately improve service-user experience of treatment by indirectly deterring coercive practices, such as seclusion and restraint, by improving staff and service-user communication and relationships.

What will taking part involve?
If you decide to participate, I would first like to interview you to establish an understanding of your current practices, particularly around formulation. This will last approximately 30-60 minutes. You will then attend four 1.5-hour training sessions on the personal narrative model and complete two rounds of questionnaires at two time-points. The first round will be at the time of the training, T1, baseline) and 30 days later (T2).

T1 questionnaires will involve completing three questionnaires, which will take around 40 minutes to combined to complete. These questionnaires measure organizational readiness for change, empathy, knowledge, and your demographics.

T2 questionnaires involve measures of empathy and knowledge and will take about 20 minutes to complete.

	Time to complete	Pre-baseline	Baseline/ training (T1)	Training	30 days post-training (T2)	Post-intervention
Consent form	5 minutes		X			
Interviews	30-60 minutes	X				
Training	4 x 1.5-hour sessions			X		
Organisational Change Questionnaire	15 minutes (18 questions)		X			
Demographic Questionnaire	5 minutes (7 questions)		X			
Knowledge Questionnaire	5 minutes (3 questions)		X		X	
Empathy Questionnaire	15 minutes (16 questions)		X		X	
Formulation Evaluation	20 minutes		X		X	
Focus Group	45 minutes					X

I would also like you to participate in a focus group to discuss your experience of the enablers and barriers to implementing the personal narrative model. Where possible, a person with lived experience of mental health challenges will join me during the interview. The interview will be digitally voice-recorded and transcribed. I anticipate the focus group to last about 45 minutes, though this may vary depending on how much you want to talk about. All interviews will take place on hospital grounds.

I would like your contact information and permission for me to use it to arrange for the interview at a later stage of the study, to send you the results of the study, and to send you a small thank-you gift in the event I am unable to give this to you in person. There is a space for your contact details on the Informed Consent form. Providing this information does not obligate you to take part in future research and will not be used for this purpose.

Do I have to take part?

No; it is entirely up to you to decide whether you want to participate. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you do decide to take part, you are still free to withdraw at any time without giving a reason. However, it may be not be possible to withdraw your interview transcript after the interview, so it is important to let me know if you feel unsure within 72 hours of the interview.

All the information you provide during the study will be kept confidential. Your personal details, including your name, contact details, and the date you signed the participant information form will be filed in a secure site, available only to the researcher and her supervisor. The information you provide will be anonymized. This anonymous data may be re-analysed and used for future research. If you decide to withdraw from the study, I would like to keep your anonymous data, but I will not collect any new data from you.

No identifiable information will be included in the transcripts and I will assign you a false name to ensure your anonymity. The transcripts will be stored on an encrypted USB memory stick before being transferred to a University password-protected computer.

All data and information relating to the study will be stored in line with [redacted] confidentiality policies and information security policies. Anonymised transcripts will only be seen by the two academic researchers, and members of a mental health service user advisory group (made up of service users with direct experience of restraint) who have inputted into the design of the study.

Are there times when confidentiality would be broken?
The only time that confidentiality would be broken, [redacted] policy, is if anything is disclosed which indicates a risk of harm to yourself or others, you reveal criminal behavior or malpractice. In this case, your supervisor will be informed; this will be discussed with you at the time of interview.

What are the potential benefits and risks of taking part?
As thanks, you will receive small gift for participating at the end of your part in the study. I do not predict there will be direct benefits to you for participating in this study. However, it is possible for you to gain a better understanding of service users and their needs, which may improve your therapeutic relationship with them. I also hope that you will feel valued in participating and helping future service users and staff.

There is a risk that the interview will raise difficult and upsetting issues as you will be asked about your experiences of life in the ward, including restraint. At any point, you may ask to move onto the next question, take a break, or end the interview without giving a reason. If any significant distress is experienced, you have the choice of contacting your GP, or a relevant helpline/website:

Rethink Mental Health: 03005000927; www.rethink.org
SANE: 08457678000; www.sane.org.uk
Mind: 03001233393l; www.mind.org.uk
Samaritans: 08457909090; www.samaritans.org
[redacted]

What will happen at the end of the research study?
A summary of the findings will be sent to you at the end of the study (if you consent to providing the researchers with an email address or home/work address for it to be sent to on the informed consent form). The results will also be written up as a paper with the aim of publication and will

be presented [redacted] managers and at events.

Who has reviewed the study?
This study has been reviewed and given a favourable opinion by North West - Liverpool East Research Ethics Committee (18/NW/0212).

What if I have a concern or question?
If you have any questions or concerns about any aspect of this study, you should ask to speak with myself, my supervisor, Emma Kaminskiy, or your line manager. Contact details are listed at the top and bottom of this form.

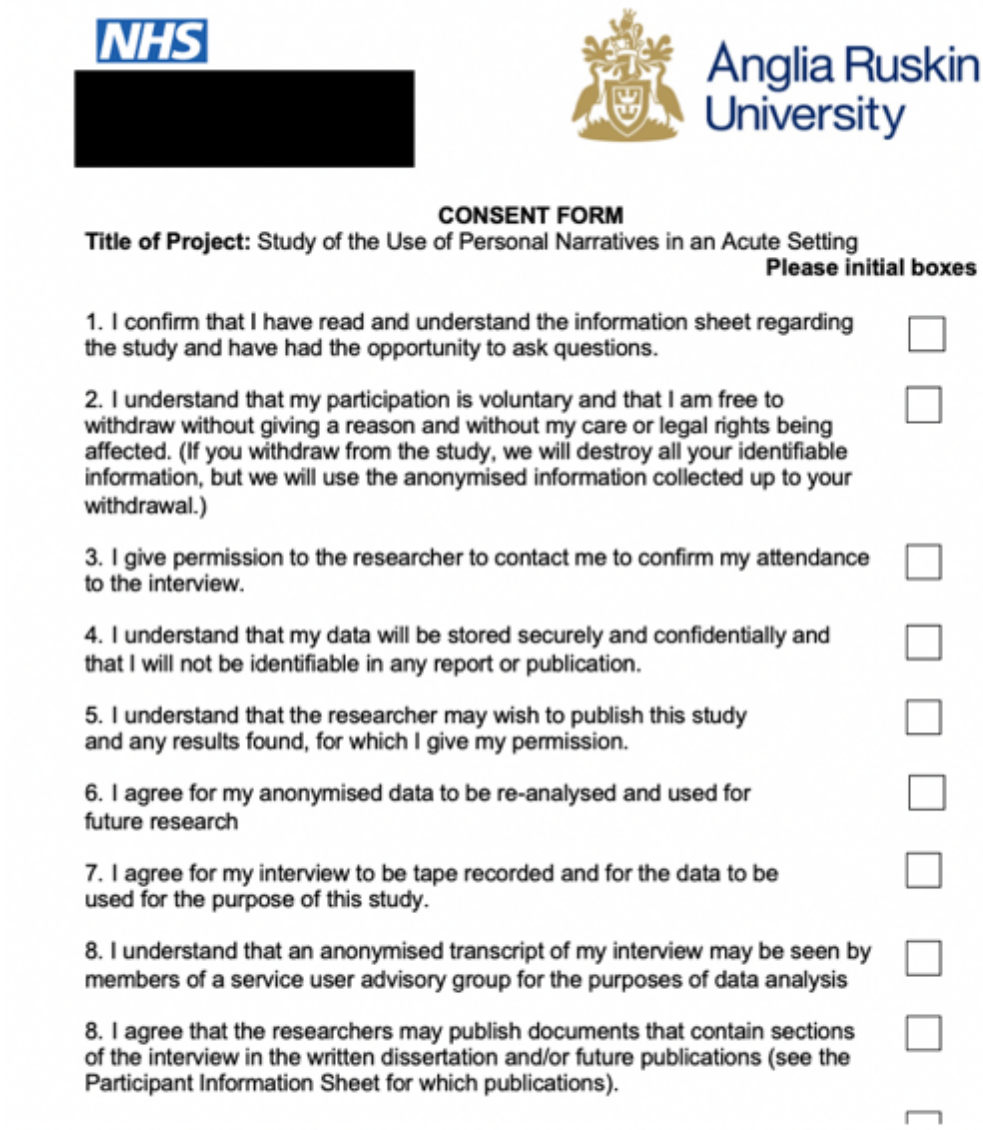
If you have a complaint about the research study and wish to speak to somebody independent of the study, you can do this by contacting the [redacted]

Contact for further information
Please contact Aneita Pringle by email at aneita.pringle@pgr.anglia.ac.uk
Please contact Dr Emma Kaminskiy at emma.kaminskiy@anglia.ac.uk

Please keep a copy of this information so you can refer to it again if you wish.

Figure D4

Staff Consent Form



NHS [redacted]

Anglia Ruskin University

CONSENT FORM

Title of Project: Study of the Use of Personal Narratives in an Acute Setting

Please initial boxes

1. I confirm that I have read and understand the information sheet regarding the study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw without giving a reason and without my care or legal rights being affected. (If you withdraw from the study, we will destroy all your identifiable information, but we will use the anonymised information collected up to your withdrawal.) ☐

3. I give permission to the researcher to contact me to confirm my attendance to the interview. ☐

4. I understand that my data will be stored securely and confidentially and that I will not be identifiable in any report or publication. ☐

5. I understand that the researcher may wish to publish this study and any results found, for which I give my permission. ☐

6. I agree for my anonymised data to be re-analysed and used for future research ☐

7. I agree for my interview to be tape recorded and for the data to be used for the purpose of this study. ☐

8. I understand that an anonymised transcript of my interview may be seen by members of a service user advisory group for the purposes of data analysis ☐

8. I agree that the researchers may publish documents that contain sections of the interview in the written dissertation and/or future publications (see the Participant Information Sheet for which publications). ☐

9. I agree to take part in the above study.

10. I agree to be contacted a future date in order to:

1. Provide a summary of the findings at the end of the study. ☐
2. Send me a small thank-you gift for participating if I am unable to receive it in person. ☐

.....	.....	.....
Name	Date	Signature
.....	.....	.....
Name of person taking consent (if not researcher, state position)	Date	Signature
.....	.....	.....
Researcher	Date	Signature
.....		.....
Participant telephone number		Participant email address / home address / work address

Figure D5

Acceptability Participant Information Sheet

A Study Exploring the 'Personal Narrative Model'

Purpose of study
The purpose of this project is to explore and improve a psychological tool that has been developed to help people make sense of their problems, identify ways forward in their lives, and support the relationship between mental health staff and service users where applicable. This tool, called the 'Personal Narrative Model' (PNM) is a type of formulation. A formulation is a collaborative process used by mental health professionals and service users/patients to provide a scaffold to better understand a person, bringing together socio, psycho, bio, and social factors that lead to the development and continuation of problems. In concrete terms, the PNM is a guide to thinking and talking about personal strengths and challenges and how services can help. If a conversation is recorded, it can take the form of a letter or diagram and is a continuous work in progress.

The PNM has undergone previous phases of development. With this phase (and with your assistance), I hope to gather further perspective on the data I have collected so far, as well as additional feedback on how it can be modified to make it more relevant for more people.

Who is the researcher?
My name is Aneita Pringle and this is a project I am completing as part of my PhD at Anglia Ruskin University in Cambridge. My supervisor is Dr Emma Kaminskiy.

Why have I been asked to participate?
You are being invited to participate because you are either a mental health practitioner with experience of working therapeutically one-to-one with service users and/or you are someone who has used mental health services (in whatever capacity). You will also be over the age of 18 and English-speaking.

Do I have to take part?

You are under absolutely no obligation to take part in this research and you can withdraw at any stage (even once the study has begun).

Participating in any way you can would be greatly appreciated, but only if you have the time and capacity! All participants can enter a prize draw to win one of two £50 Amazon gift vouchers.

Does this study have ethical approval?
This study has received ethical approval from the Psychology Department at Anglia Ruskin University, Cambridge.

What will happen to the results of the study?
The results of this study will be written up for my dissertation and will be submitted to academic conferences, journals, and other publications in the hopes of presenting or publishing them. I will also write summaries of the results for the purpose of sharing this research with the wider community, including yourself, should you wish to be sent a copy.

Contact for further information
If this sounds like something you might like to get involved in or if you have any questions, please contact me (Aneita) at aneita.pringle@pgr.anglia.ac.uk.

What would I need to do?

Phase 1 (approx. 45 minutes)
Lived experience participants:

- You will view a 15-minute video explaining the PNM and respond to questions about it (e.g. is it similar/different to your views of mental health) as well as your wider experiences (e.g. have you worked together with staff to understand your strengths before?) The questions will take approximately 20 minutes to complete.

Practitioners:

- You will view a 15-minute video explaining the PNM and respond to questions about it (e.g. is it similar/different to your views of mental health?)
- View a 10-minute video exploring the PNM's acceptability research results and respond to questions about it (e.g. recruitment numbers). The questions will take approximately 20 minutes to complete.

Phase 2 (approx. 1 hour)
If you indicate you are interested, you will:

- Participate in a focus group or an interview where we will discuss how to enhance the training and application of the PNM.

Are there any possible disadvantages or risks to taking part?
This study should not present any more risk to you than what you face in your everyday life. Participating in the interview or focus group presents a risk that the discussion may touch on distressing topics, but I will not be asking sensitive questions.

You are encouraged to take rest breaks when you need them at any point in the process and you can decline to answer any questions you wish.

Can I withdraw at any time, (and if so, how)?
You can withdraw from the study at any time and without giving a reason; just let me (Aneita) know by emailing me. If you wish to also have your data removed, I will be able to remove your data up to the point when I start to analyse it, which will be approximately 1 week from the time you participate.

Will what I share be passed on to others?
Only in the unlikely event that you disclose information that indicates you or someone else is at risk of harm, I am obligated to share this with my supervisor and further actions may be taken.

Summary of research findings
If you wish to receive a summary of findings once they are available, please let the me know by email.

GDPR and Personal Data
I need to make you aware that 1) myself and my supervisory team are in sole control of this research. 2) I will be asking you some questions related to your personal data. This includes demographic questions (e.g. how long you've worked or used services) as well as your opinions on the Personal Narrative Model.

What will you do with my data?
I will be assigning you a participant number so your real name will never be revealed in any publications. I will be changing or removing any other names, places, or any other details from your responses so that they can't be used to identify you. Please bear in mind that despite these steps, there is still a chance you might be identified (for example, by your peers or colleagues). I intend to quote what you say in any publications, which increases this risk.

You should know that if you participate in the focus group, other people in the focus group may recognise you.

Once the data has been altered so you are not identifiable, I will be sharing it with my supervisory team and a Service User Advisory Group, who are people with lived experience of mental health difficulties and have been advising me throughout my research. Data will be destroyed after five years.

Data Protection
Phase 1:
Your data will be stored securely by Qualtrics (an online survey platform) whose privacy policy you can find here: https://www.qualtrics.com/privacy-statement/ and their information on GDPR is here: https://qualtrics.com/gdpr. Qualtrics has signed up to the US-EU 'Privacy Shield' which is a commitment to preserve current UK data privacy rights where data may be stored in the U.S. Compliance with ARU's Guidance for Online Surveys (www.anglia.ac.uk/researchethics) will be upheld at all times.

I will download your data from Qualtrics and save it as a password-protected file. This data will remain and securely held in the European Economic Area.

Phase 2:
With your permission, I will be recording interviews and focus groups using Microsoft Teams or another appropriate video-chat platform. I will transcribe the discussion (with identifying details altered or removed), then delete the recording. All data will be password-protected and stored securely in the European Economic Area.

Contact details for complaints
If you have any complaints about the study, please contact myself or my supervisor, Dr. Emma Kaminskiy (emma.kaminskiy@anglia.ac.uk). Alternatively, you may wish to make a complaint by emailing complaints@aru.ac.uk or via post using the following address: Office of the Secretary and Clerk, Anglia Ruskin University, Bishop Hall Lane, Chelmsford, Essex, CM1 1SQ.

https://www.anglia.ac.uk/privacy-and-cookies/research-participants

Please visit this link for information about how long we keep your data, how we keep your data secure, how you can exercise your rights over your data, and make a complaint over our use of your data.

2

Figure D6

Acceptability Consent Form

PARTICIPANT CONSENT FORM

Title of the project: A Study Exploring the 'Personal Narrative Model'
Main investigator and contact details: Aneita Pringle; aneita.pringle@pgr.anglia.ac.uk
Members of the research team: Dr. Emma Kaminskiy (primary supervisor); Dr. Jonathan Totman; Dr. Tine Van Bortel; Dr. Mick Finlay

1. I agree to take part in the above research. I have read the Participant Information Sheet (08 July 2020, V1.2) for the study.
   I understand what my role will be in this research, and all my questions have been answered to my satisfaction.

2. I understand that I am free to withdraw from the research at any time, without giving a reason.

3. I am free to ask any questions at any time before, during, and after the study.

4. I understand what information will be collected from me for the study.

5. For the purposes of the Data Protection Act (2018), if this project requires me to produce personal data, I have read and understood how Anglia Ruskin University (or name of institution of based at another organisation) will process it.

6. I understand what will happen to the data collected from me for the research.

7. I have been told about any disadvantages or risks regarding me taking part.

9. I understand that quotes from me may be used in the dissemination of the research.

10. I understand that the interview or focus group will be recorded.

11. I have been informed how my data will be processed, how long it will be kept and when it will destroyed.

12. I have been provided with a copy of this form and the Participant Information Sheet (08 July 2020, V1.2).

13. I confirm I am 18 years of age or older, English-speaking and are either/or a mental health practitioner with experience of working therapeutically one-to-one with service users and/or an individual who has used mental health services.

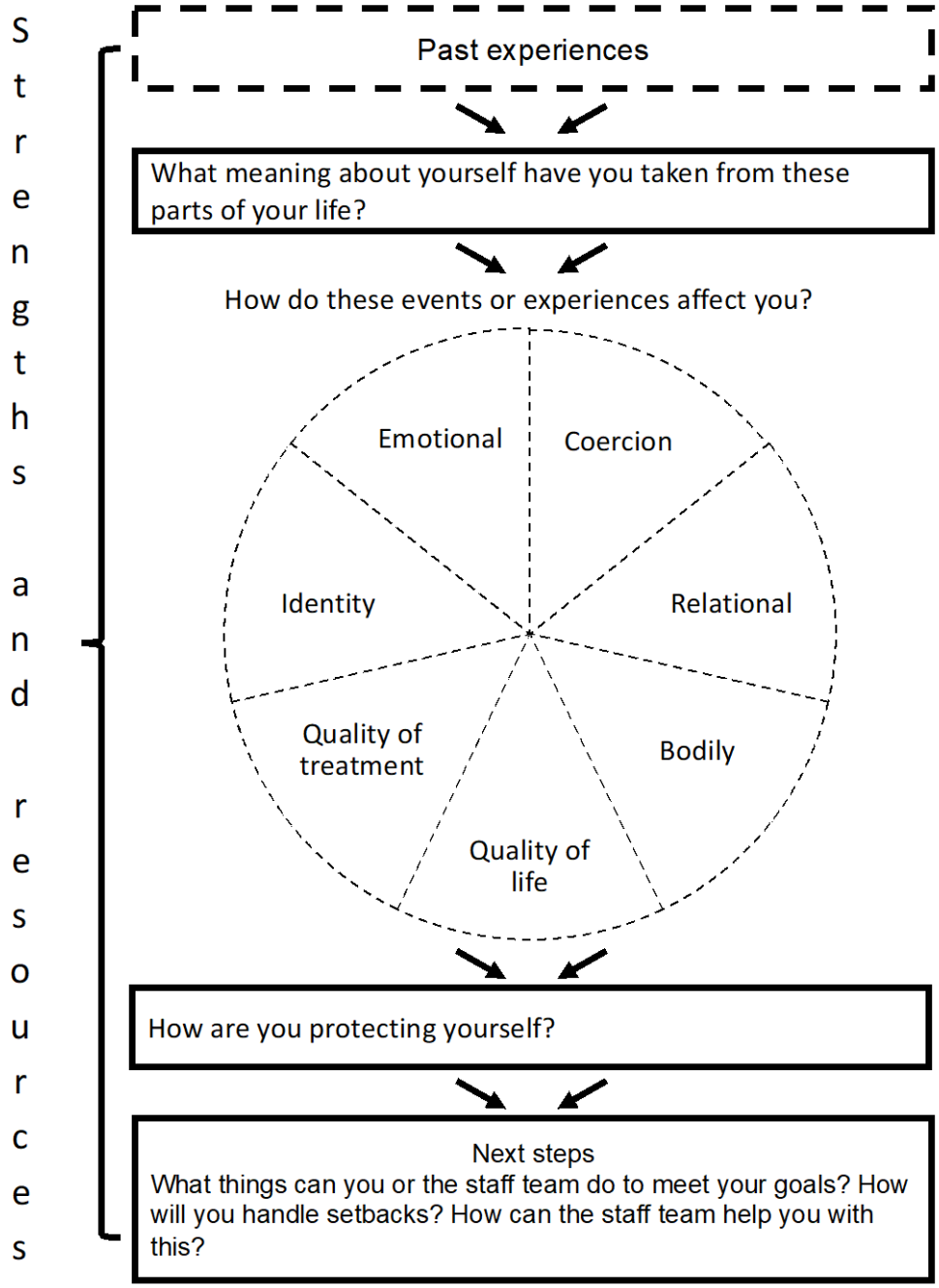
If you wish to withdraw from the research within a week of participating, please email me at aneita.pringle@pgr.anglia.ac.uk *stating the title of the research. You do not have to give a reason for why you would like to withdraw.*

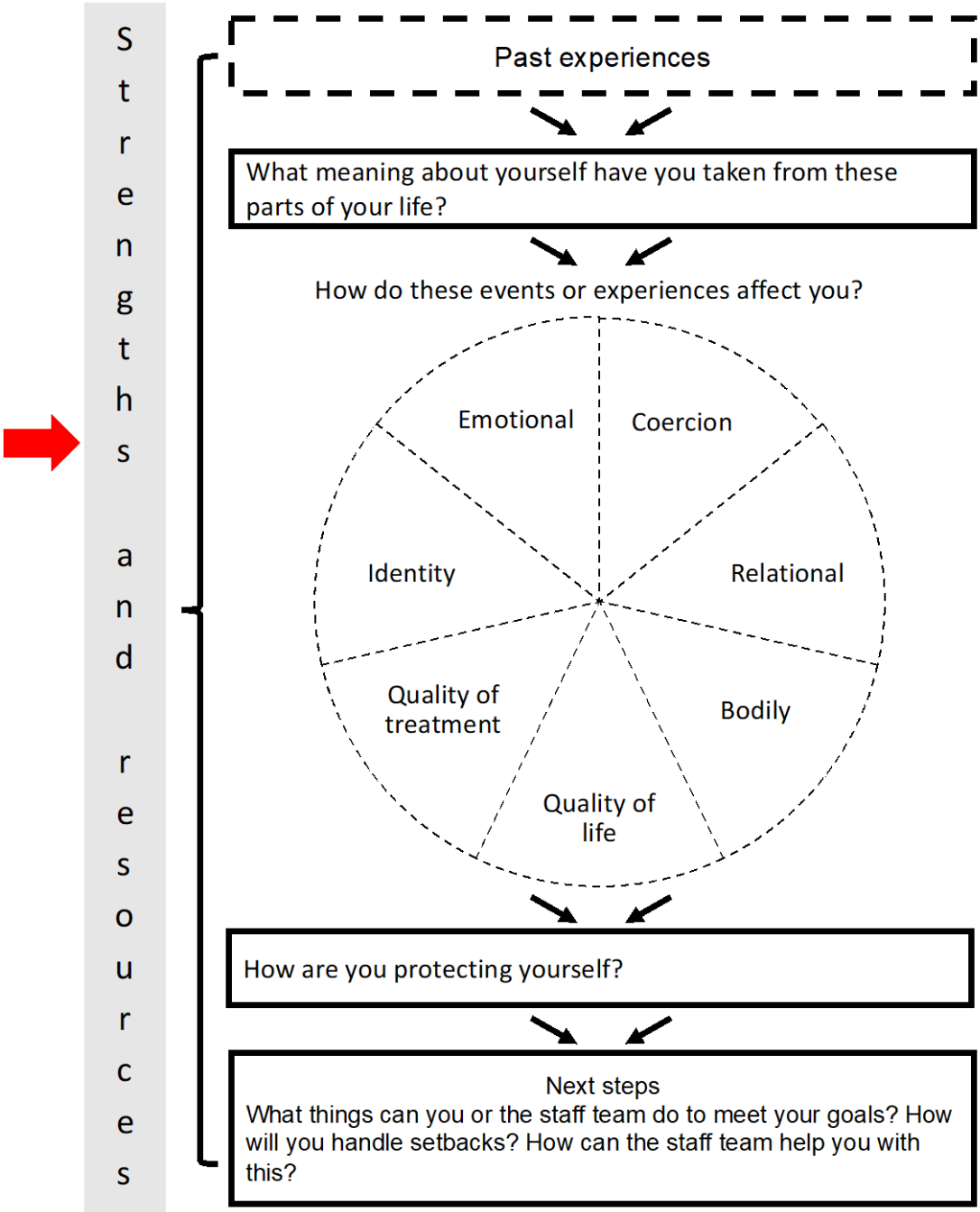
Please let me know whether or not you are happy for data that has been collected up to this point to still be used. Should you wish for any data to also be removed, you are completely free to ask, provided you notify me within the time stated above.

Appendix E

The Personal Narrative Model Guide

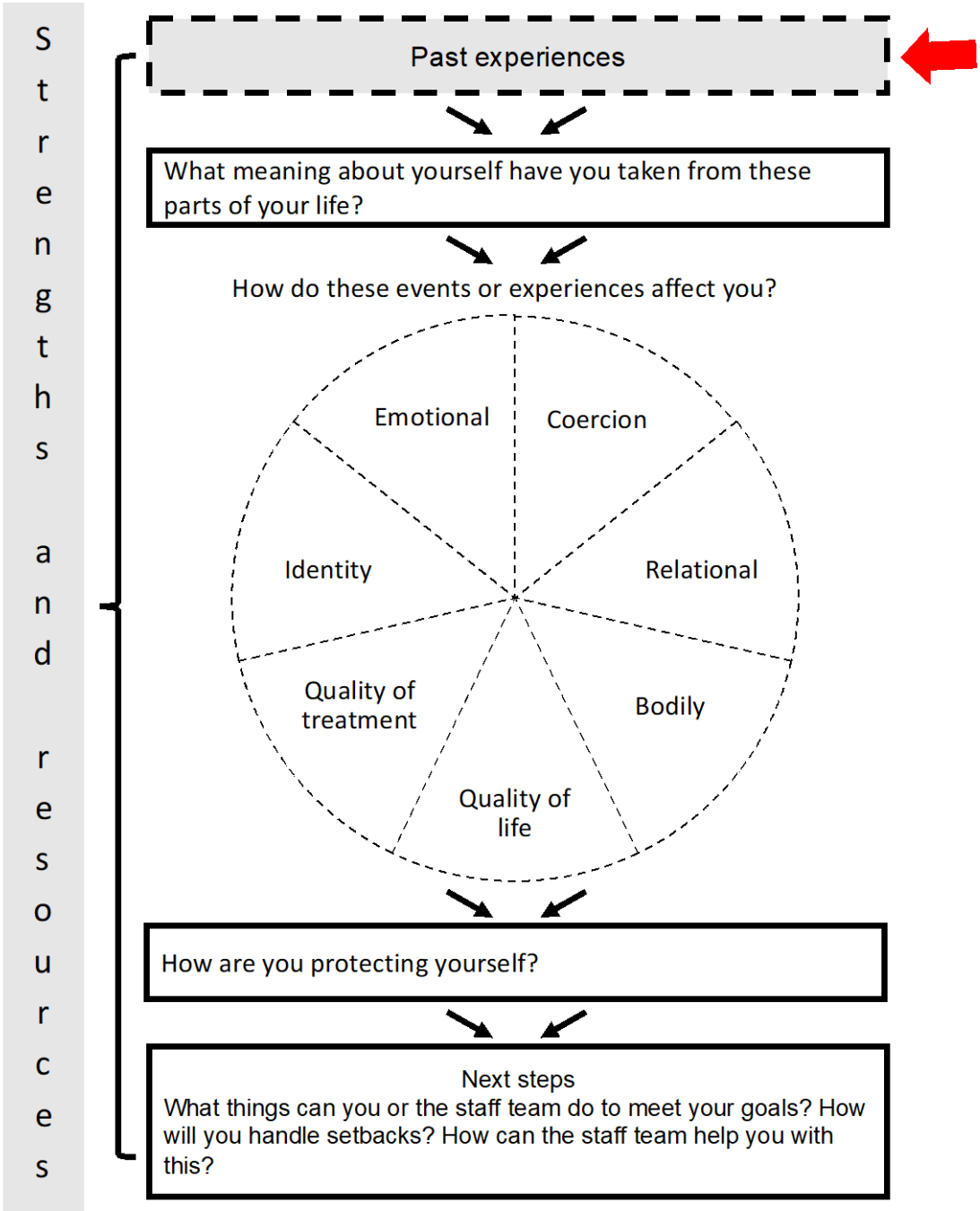
Figure E1




Strengths and resources
Past experiences
What meaning about yourself have you taken from these parts of your life?
How do these events or experiences affect you?
Emotional
Coercion
Identity
Relational
Quality of treatment
Bodily
Quality of life
How are you protecting yourself?
Next steps
What things can you or the staff team do to meet your goals? How will you handle setbacks? How can the staff team help you with this?

Strengths and resources

We will be thinking about positive experiences, qualities, skills, and resources throughout this discussion. Let's try to think of at least one or two positive things per section.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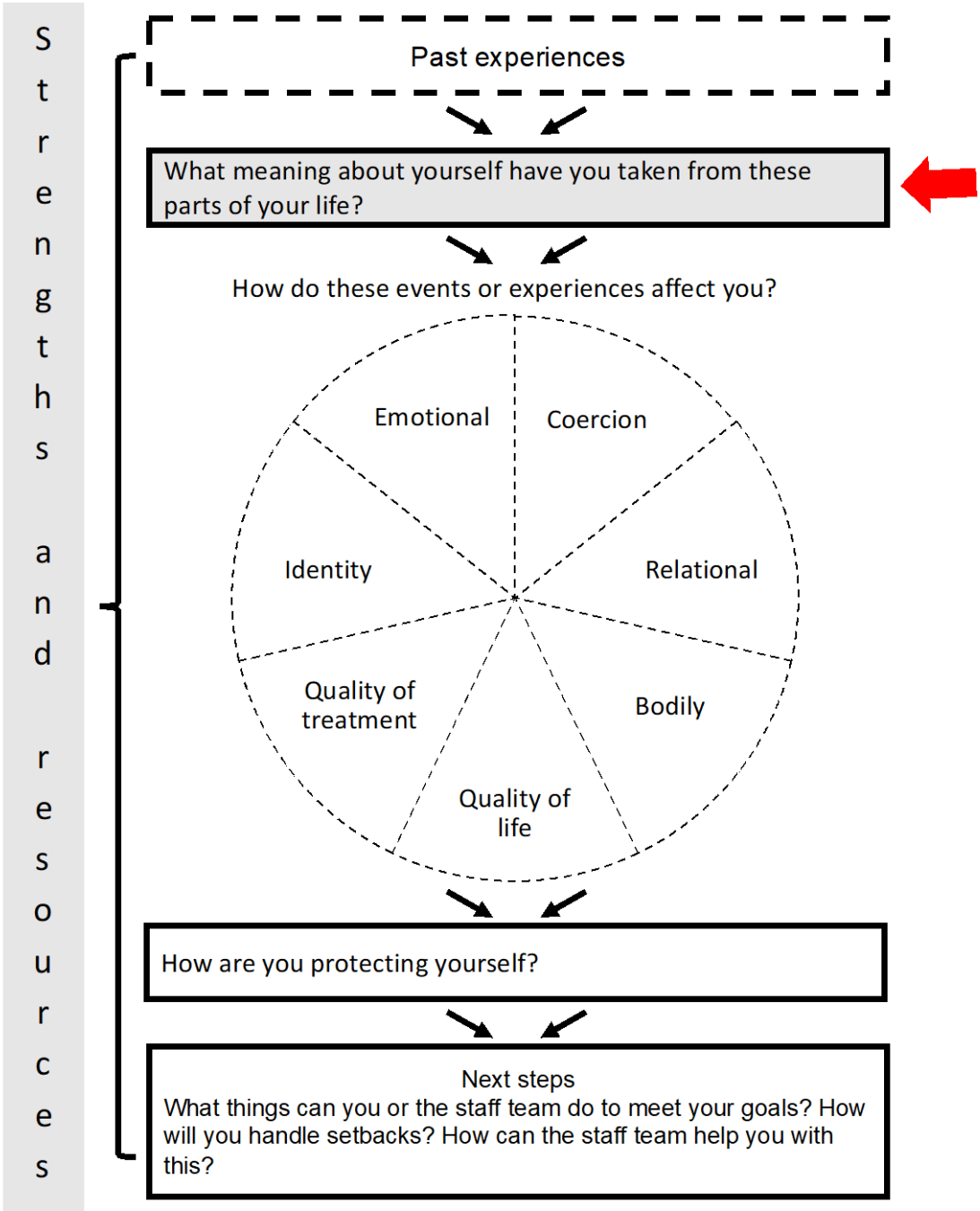
Quality of life
How are you protecting yourself?
Next steps
What things can you or the staff team do to meet your goals? How will you handle setbacks? How can the staff team help you with this?

Past experiences

Using this box, please describe what has happened to you leading up to your admission to the ward. Try to include at least 1-2 good things that happened.

Would you like to talk more about your past or your life outside the ward with someone?

Past experiences (including both negative and positive) will be acknowledged but contained. The box is perforated to convey that we are acknowledging potential trauma and adversity but not focusing on it.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How are you protecting yourself?
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What things can you or the staff team do to meet your goals? How will you handle setbacks? How can the staff team help you with this?

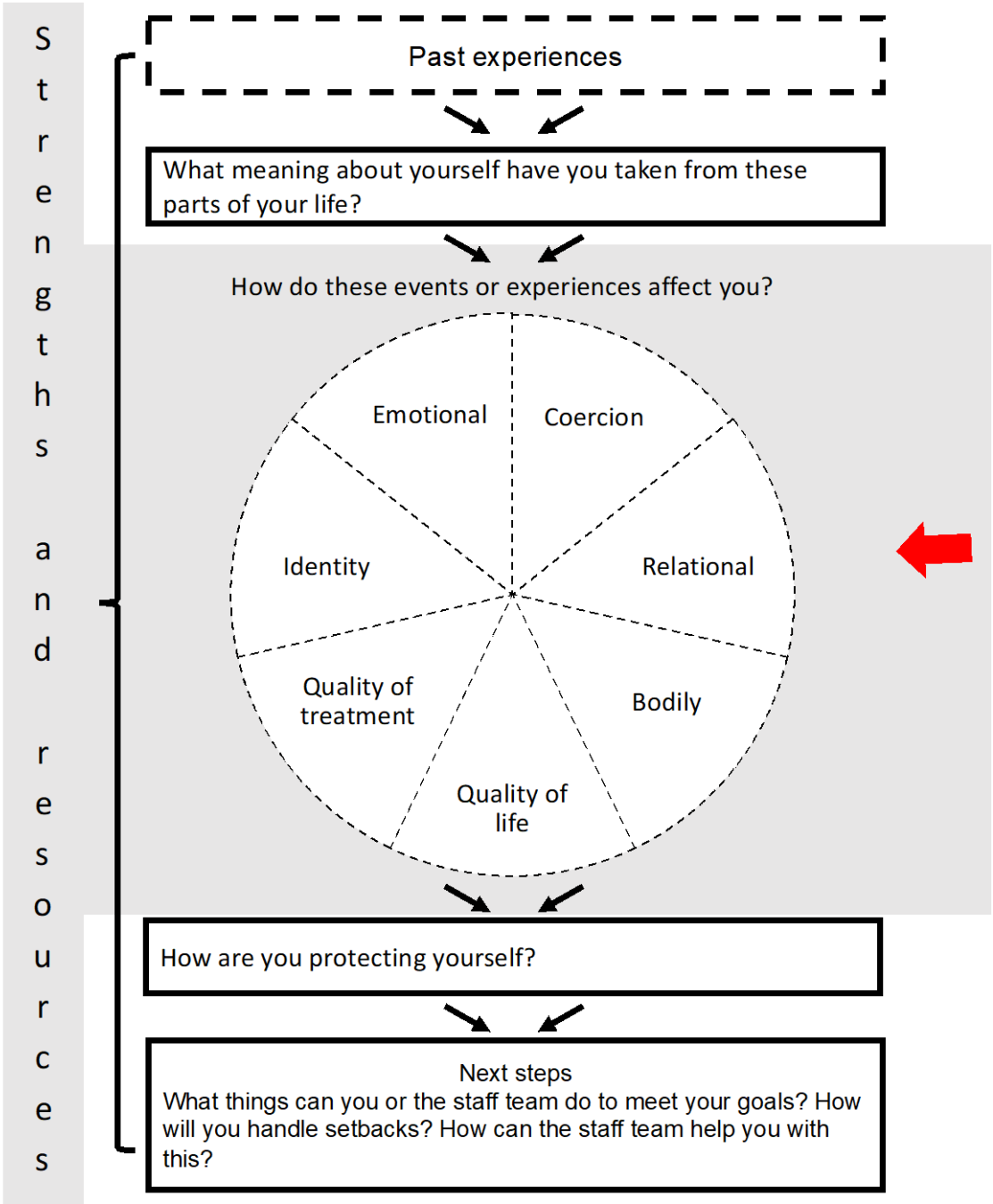
Meaning: what sense did you make of it?

Again, try to think of 1-2 positive meanings.

Meaning: What sense do you make of your experiences?

Unsafe, afraid, attacked	Trapped
Abandoned, rejected	Defeated
Helpless, powerless	Failed, inferior
Hopeless	Guilty, blameless, responsible
Invaded	Betrayed
Controlled	Shamed, humiliated
Emotionally overwhelmed	Sense of injustice/unfairness
Emotionally 'empty'	Sense of injustice/unfairness
Bad, unworthy	Contaminated, evil
Isolated, lonely	Alien, dangerous
Excluded, alienated	Different, 'abnormal'
Special, unique	Talented
Creative	

This is not an exhaustive list but introduces examples of meanings service users can potentially identify with. Adapted from the Power Threat Meaning Framework (DCP, BPS, 2018).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THREAT: how did it/is it affecting you?

Again, try to think of 1-2 of your resiliency resources.

Identity

- Lack of support to develop one's identity; loss of social, cultural or spiritual identity; the adoption or imposition of devalued, subordinate or shameful identities relating to oneself or one's social group; activism; culturally supported rituals

Emotional

- Feeling emotionally overwhelmed; writing; exercise; creativity and the arts

Coercion

- Restraint/seclusion, involuntary hospitalisation, lack of safety, physical threat

Relational

- E.g. Disrupted attachments, abandonment, betrayal, isolation, shaming and humiliation, rejection, hostility, neglect, bereavement, lack of protection, entrapment, threats to boundaries, autonomy/control, self-concept, and identity formation, invalidation; using healing attachments/relationships for practical and emotional support

Bodily

- Medication side-effects, ill health, chronic pain, injury, physical disability, loss of function; nutrition; exercise; rest

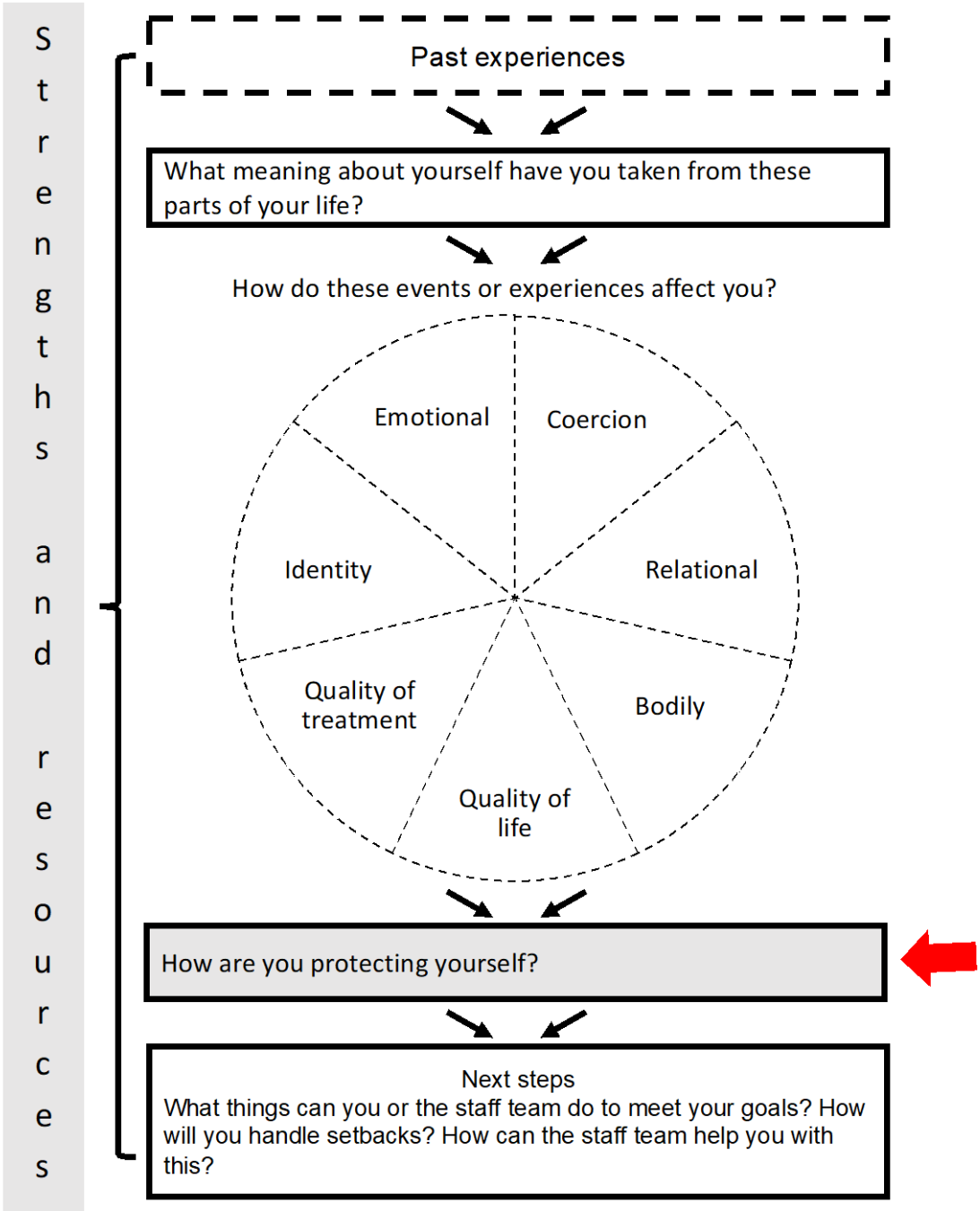
Quality of life

- Feeling entertained, fulfilled, safe, adequate money, satisfaction with room in ward

Quality of treatment

- Staff availability, feeling heard, feeling informed of treatment, agency in treatment

Potential areas of distress or salience; some areas may not be relevant to service users or their experiences may span outside the areas named. The separation of each area is for clarity of explanation as each area will affect and be affected by the rest.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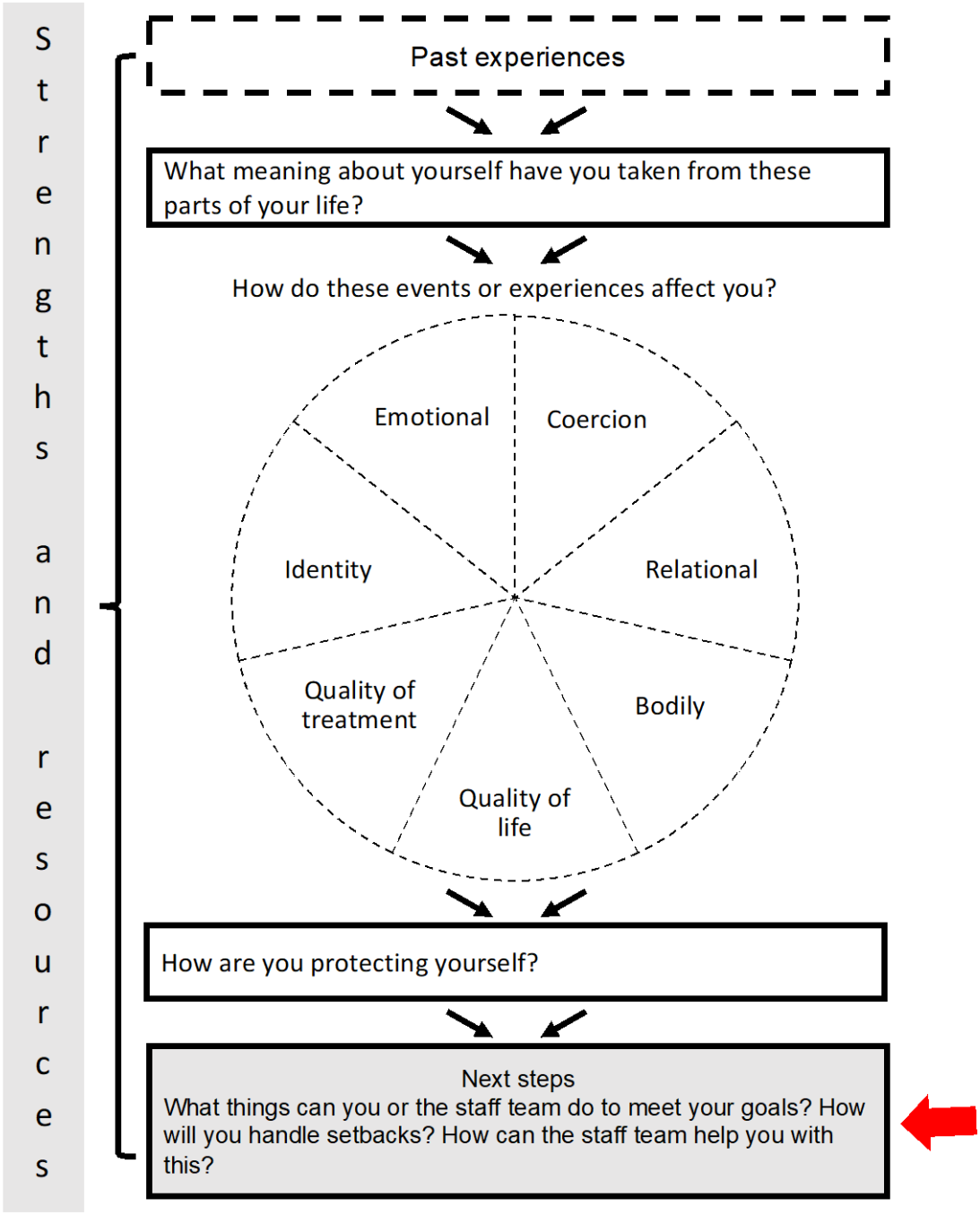
What things can you or the staff team do to meet your goals? How will you handle setbacks? How can the staff team help you with this?

Threat responses

How are you protecting yourself? *This is not an exhaustive list but introduces examples of meanings service users can potentially identify with. Taken from the Power Threat Meaning Framework (DCP, BPS, 2018).*
The purpose of each of these reactions is survival, and so is by definition a strength, but the reactions themselves may no longer suit its purpose. Some examples which you may find relevant to you are listed below. This is not an exhaustive list and some responses may not apply to you or are not listed.

Protection from physical danger	E.g. by hypervigilance, insomnia, flashbacks, nightmares, fight/flight/freeze, suspicious thoughts, isolation, aggression
Maintaining a sense of control	E.g. by self-starvation, rituals, violence, dominance in relationships
Seeking attachments	E.g. by idealisation, appeasement, seeking care and emotional responses, use of sexuality
Protection against attachment loss, hurt and abandonment	E.g. by rejection of others, distrust, seeking care and emotional responses, submission, self-blame, interpersonal violence, hoarding, appeasement, self-silencing, self-punishment
Preserving identity, self-image and self-esteem	E.g. by grandiosity, unusual beliefs, feeling entitled, perfectionism, striving, dominance, hostility, aggression
Preserving a place within the social group	e.g. by striving, competitiveness, appeasement, self-silencing, self-blame
Meeting emotional needs/self-soothing	E.g. by rocking, self-harm, skin-picking, bingeing, alcohol use, over-eating, compulsive sexuality
Communication about distress, elicit care	E.g. by self-injury, unusual beliefs, voice-hearing, self-starvation
Finding meaning and purpose	E.g. by unusual beliefs, overwork, high moods

Taken from the Power Threat Meaning Framework (DCP, BPS, 2018).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Next Steps, Strengths & Resources

Identity

- Spirituality/Religion:
  - Do you have any belief in a higher power or force for good (such as God)? If so, is your faith or spiritual belief important for your recovery?
  - Would you like to change anything about your experience of spiritual or religious beliefs and/or experiences?
  - (If yes) What would you like to change (e.g. more support attending services, or coping with difficult thoughts caused by beliefs)
  - (If yes) What do you currently have (support/services) that would help you meet your goals?
- Culture:
  - Have you experienced a loss of your cultural identity?
  - Would you like to change anything about your cultural identity?
  - (If yes) how much help (e.g. support from members of your community) would you need to meet this/these goal(s)?

Emotion

- Has there been anything difficult for you to deal with while in the ward?
- (If yes) What have these feelings or experiences been? How have they affected your usual activities? Are there warnings that these experiences are about to become worse or more intense? If yes, what are these signs?
- Would you like to change the feelings or experiences you have been experiencing? E.g. Would you like to learn to better recognise signs and manage your symptoms? Who would you like to help you with this goal?

Coercion

- Restraint/seclusion
  - Have you experienced/witnessed restraint or seclusion recently or do you feel this may happen?
  - Would you like to reduce chances you will be restrained or secluded?
  - (If yes) How could you reduce this?
  - What do you currently have (support/services) that would help you meet your goal(s)?
  - What type of help (e.g. support or services) would you need to meet your goal(s)?

The service user may not have the answers to how they might go about addressing (or identifying), or there may be disagreement between the service user's perspective and the wider team's. This can be illuminated in the team formulation and its communication to the service user in an iterative manner.

Next Steps, Strengths & Resources

Relational

- Would you like to improve your relationships with staff in the ward?
- Would you like to improve your relationships with people (in general)? Friends, family, or intimate partner?
- (If yes) How could you meet this goal(s)?
- What do you currently have (support/services) that would help you meet your goal(s)?
- What type of help (e.g. support or services) would you need to meet your goal(s)? How much help do you think you need? Who would you like to help you with this goal?

Bodily

- Is medication part of your treatment?
- How do you feel about your medication? Is it helpful?
- How do you feel about the medication you take and the dosage?
- Would you like to learn more about your medication?
- (If yes) How much help or support would you need to learn more about your medication? Who would you like to help you with this goal?

(Prompts) Other physical ill health, physical disability, injury, etc.

Quality of life

- Is there anything bothering or worrying you about your life in the ward you would like to improve?
    - For example:
        - The fun you have in the ward
        - The money you have in the ward
        - Your personal safety in the ward
        - Your room in the ward
- (If yes) What would you like to change, if anything?
- What type of help (e.g. support or services) would you need in order to change this/these aspect(s) of your life? How much help or support would you need to meet that goal? Who would you like to help you with this goal?

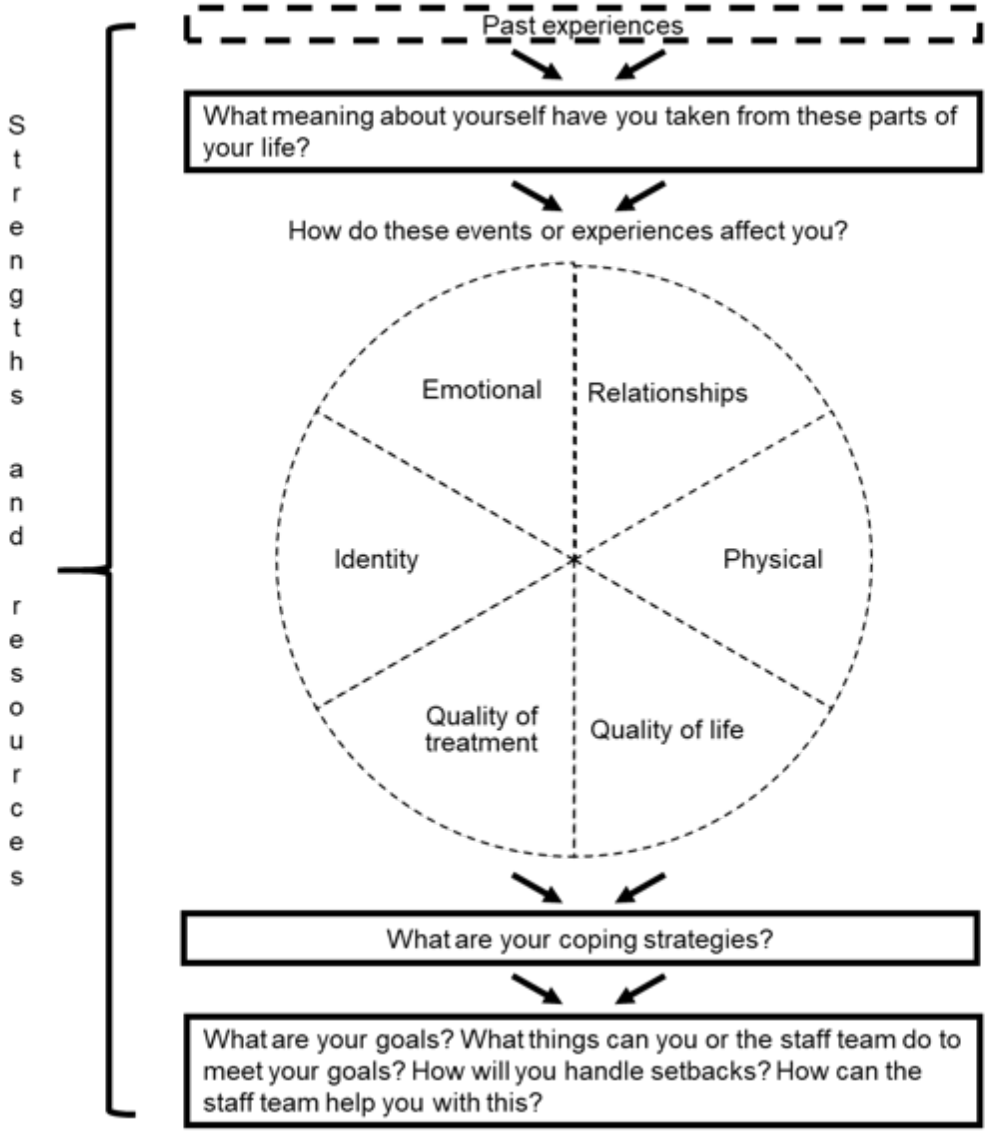
Quality of treatment

- How do you feel about the staff's availability, listening to your concerns, availability, explanation of your treatment?
- What would you change about your treatment, if anything?
- What help would you need to change your treatment? How much help do you need? Who would you like to help you with this goal?

Appendix F

The Personal Narrative Model Template

Figure F1



Strengths and Resources

Try to think about your positive experiences, qualities, skills, and resources throughout this discussion. Try to think of at least one or two positive things per section.

Past Experiences

Using the box below, you will describe what has happened to them leading up to your admission to the ward. Please try to include at least 1-2 good things that happened.

Meaning

What sense did you make of your past experiences? Again, 1-2 you are to think of 1-2 positive meanings.

Challenges

Think together about how your past experiences and the meaning you took from them are affecting you currently (what your current problems are). Again, try to think of 1-2 resiliency resources.

Ways of Coping
What are your coping strategies? In other words, how are you protecting yourself? The purpose of each of these reactions is survival, and so is by definition a strength, but the reactions themselves may no longer suit its purpose.

Next Steps
What are the important areas of your life? Would you like to change anything about it/them? What would you like to change? What support do you have (resources/services) that would help you meet your goals?

Appendix G

Quantitative Acceptability Questionnaire Results

Quantitative Acceptability Questionnaire Results

Questionnaire item	Freq (%)	Freq (%)	Freq (%)	Freq (%)	Freq (%)	Freq (%)	Freq (%)
How acceptable would you find the PNM to help treat mental health distress?	Very acceptable	Acceptable	Slightly acceptable	Moderately acceptable	Slightly unacceptable	Unacceptable	Not at all acceptable
Practitioners / with lived experience	8 (66.7)	4 (33.3)					
Lived experience	5 (35.7)	9 (64.3)					
How consistent is the PNM with your common sense or everyday notions about what a care planning tool for mental health should be?	Very consistent	Consistent	Slightly consistent	Moderately consistent	Slightly inconsistent	Inconsistent	Very different or inconsistent
Practitioners / practitioners with lived experience	7 (58.3)	3 (25.0)	2 (16.7)				
Lived experience	4 (28.6)	6 (42.9)	4 (28.6)				
To what extent do you think there might be risks in undergoing the PNM?	No risks are likely	Risks are not very likely	Risks are slightly unlikely	Some risks are likely	Risks are slightly likely	Risks are likely	Lots of risks are likely
Practitioners / practitioners with lived experience	2 (16.7)	3 (25.0)		4 (33.3)	2 (16.7)	1 (8.3)	
Lived experience	6 (42.9)	4 (28.6)		3 (21.4)	1 (7.1)		
How much do you like the steps or factors involved with the PNM?	Like them very much	Somewhat like them	Slightly like them	Moderately like them	Slightly dislike them	Somewhat dislike them	Do not like them at all
Practitioners / practitioners with lived experience	8 (88.7)	4 (33.3)					

Lived experience	6 (42.9)	7 (50)		1 (7.1)			
How effective do you think the PNM is likely to be?	Very effective	Somewhat effective	Slightly effective	Moderately effective	Slightly ineffective	Somewhat ineffective	Very ineffective
Practitioners / practitioners with lived experience	5 (41.7)	7 (58.3)					
Lived experience	6 (42.9)	8 (57.1)					
How likely is the PNM to make permanent improvements to mental health?	Very likely	Somewhat likely	Slightly likely	Moderately likely	Slightly unlikely	Somewhat unlikely	Unlikely
Practitioners / practitioners with lived experience	6 (50)	5 (41.7)	1 (8.3)				
Lived experience	4 (28.6)	9 (64.3)	1 (7.1)				
To what extent do you think downsides are likely to result from the PNM treatment?	No downsides likely	A couple downsides likely	A few downsides likely	Some downsides would occur	Downsides likely	Several downsides likely	Many downsides likely
Practitioners / practitioners with lived experience	3 (25.0)	4 (33.3)	3 (25)		1 (8.3)	1 (8.3)	
Lived experience	3 (21.4)	6 (42.9)	4 (28.6)		1 (7.1)		
How much discomfort do you think is likely to be experienced during the development of the PNM?	No discomfort at all	Slight discomfort	Some discomfort	Moderate discomfort	Much discomfort	Mostly discomfort	
Practitioners / practitioners with lived experience	1 (8.3)	5 (41.7)	3 (25.0)	3 (25.0)			
Lived experience	2 (14.3)	6 (42.9)	3 (21.4)	3 (21.4)			
Overall, what is your general reaction to the PNM?	Very positive	Positive	Slightly positive	Ambivalent	Slightly negative	Negative	Very negative
Practitioners / practitioners with lived experience	8 (66.7)	3 (25.0)	1 (8.3)				

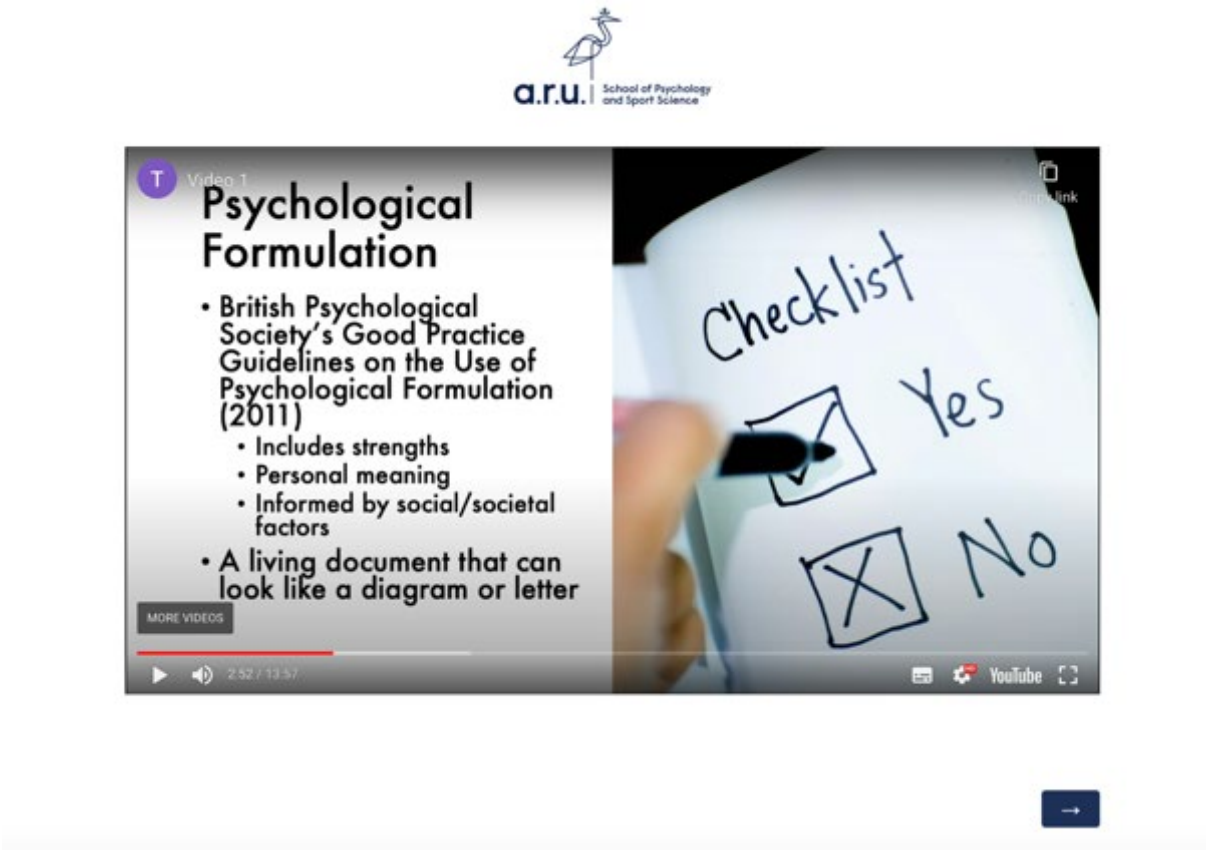
Lived experience	6 (42.9)	6 (42.9)	1 (7.1)	1 (7.1)			

Appendix H

Online Acceptability Video Screenshots and Links

Figure H1

Online Acceptability Phase Video 1 Screenshot



Video 1 link

https://youtu.be/0bvqd7VyIkw

Figure H2
Online Acceptability Phase Video 2 Screenshot

Video 2 link

https://youtu.be/U5aXRtmsPmY